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ABSTRACT

The report explores the feasibility of placing 565 severely mentally retarded residents of the Georgia Retardation Center and Southwestern Developmental Center at Bainbridge, Georgia, in alternative community living and daytime arrangements. The seven mental retardation service areas which had placed most of these residents were the focus of intensive review through site visits, systematic surveys, key-informant interviews, and review of existing records. Project objectives included analyses of service demand, community support, staff availability, system management, service capacity, and start-up costs. Part One outlines the study methodology, describes the target population and target facilities, assesses components of the community and state system, reviews characteristics of service personnel, and raises issues central to institutional phase-down. Part Two contains strategy recommendations for personnel recruitment and retention, describes services required to meet the needs of the target population and the costs of those services, suggests sources of funding, proposes a transition strategy, and lays out an implementation schedule. Appendices include references, sample surveys, sample standards for South Carolina facilities serving persons with developmental disabilities, tables showing projected service requirements and costs, and architectural designs and estimated costs for community living facilities. (JW)

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THE GEORGIA FEASIBILITY STUDY:

THE DEVELOPMENT OF ALTERNATIVE COMMUNITY SERVICES FOR THE CURRENT RESIDENTS OF GEORGIA RETARDATION CENTER AND THE SOUTHWEST DEVELOPMENTAL CENTER AT BAINBRIDGE

SEPTEMBER 1987

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TABLE OF CONTENTS

PART ONE

Section Page

I. **INTRODUCTION** 1

II. **PROJECT METHODOLOGY** 3

A. Introduction 3

B. Surveys of Persons with Mental Retardation .6

- 1. Classifying Individuals by Level of Functioning 7
- 2. Data Collection Using the Inventory for Client and Agency Planning (ICAP). . . .13
- 3. Clients Waiting for Services 16

C. Site Reviews and Interviews 16

- 1. Site Reviews 16
- 2. Key Informant Interviews 17

D. Family Survey 18

E. Provider Survey 18

- 1. Design of Survey Form 19
- 2. Sampling Plan and Survey Distribution 19
- 3. Compilation of Survey Information 22

F. Manpower Assessment 24

G. Zoning and Local Code Reviews 25

H. Service Utilization and Cost Projections 25

1. Ongoing Service Requirements and Costs 25
2. Change Management and Start-up Costs 28
3. Capitol Costs 28

J. Review of Documents 29

III. WHO ARE THE TARGET POPULATIONS OF CONCERN?. . 30

A. Target Population 30

1. Where Do They Live?. 30
2. Description of the Institutional Population. 31
3. Description of Those on the GRC Waiting List 34
4. Target Populations by Planning Group 36

B. Other Populations of Concern 40

1. Description of Persons Receiving Services in the Seven Mental Retardation Service Areas 40
2. Description of Individuals Receiving and Awaiting Community Services by Planning Group 42

C. Comparison of All Study Populations by Planning Group 48

IV. WHAT DOES THE CURRENT COMMUNITY SYSTEM LOOK LIKE? 53

A. Introduction to the Community System 53

B. Types of Day and Residential Services Offered 54

C. Specialized Support Services Offered 57

D. Who Provides Care? 60

E. Administrative Issues 68

  1. Quality Assurance 68
  2. Data Collection and Program Management 69
  3. Case Coordination 70

F. Community Acceptance 72

G. Future Program Priorities 74

V. WHAT DOES THE STATE SYSTEM LOOK LIKE? 76

A. Quality Assurance 76

  1. Licensing .77
  2. Standards .77
  3. Program Monitoring 78
  4. Control and Response 79
  5. Grievance Mechanisms 79

B. Funding 79

C. Interagency Collaboration 81

VI. WHAT ARE THE ISSUES TO CONSIDER IN EXPANDING COMMUNITY SERVICES? 82

A. Fund Allocation 82

B. Service Availability 83

  1. Residential Services 83
  2. Day Services 84
  3. Medical/Health Services 85
  4. Specialized Support Services 87
  5. Caretaker Supports 89

C. Labor Availability 91

  1. Southern Target Counties 93

    2. Northern Target Counties 97

D. Community Acceptance 100

E. Quality Assurance and Licensing 102

    1. Standards 102
    2. Licensing 105
    3. Monitoring 106
    4. Client Rights 106

F. Training and Technical Assistance 106

    1. Staff Training 106
    2. Technical Assistance 108

G. Target Populations 108

VII. WHAT ARE THE CONCERNS OF FAMILIES? 109

A. Introduction. 109

B. The Role of Families in Service Provision. . . .110

C. Methods. 112

D. Results. 113

    1. The Family Respondents. 113
    2. Characteristics of the Relatives. 114
    3. Satisfaction with Services and Perceptions of Happiness. 117
    4. Frequency of Visits. 119
    5. General Opinions. 120
    6. Concerns. 121

E. Discussion. 123

LIST OF FIGURES

FIGURE PAGE

FIGURE 1 : SEVEN SELECTED PROGRAM AREAS. 4

FIGURE 2: KEY PROJECT OBJECTIVES BY DATA COLLECTION STRATEGY. 6

FIGURE 3: STRATEGY FOR CLASSIFYING PERSONS WITH DISABILITIES. 8

FIGURE 4: TEN PLANNING GROUPS FOR PERSONS WITH MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES. 12

FIGURE 5: PERSONS ASSESSED USING THE ICAP BY SAMPLING PROCEDURE. 14

FIGURE 6: SURVEYS DISTRIBUTED BY 27 PROGRAM REGIONS. 21

FIGURE 7: PATTERN OF RETURNED SURVEY FORMS. 23

FIGURE 8: SERVICE TAXONOMY. 27

FIGURE 9: SUMMARY OF CHARACTERISTICS OF RESIDENTS AT GRC AND BAINBRIDGE. 33

FIGURE 10: SUMMARY OF CHARACTERISTICS OF PERSONS ON THE GRC WAITING LIST. 35

FIGURE 11: TARGET POPULATIONS BY PLANNING GROUP AND AGE. 37

FIGURE 12: SERVICE AREA OF ORIGIN OF BAINBRIDGE RESIDENTS BY PLANNING GROUP AND AGE. . . . 38

FIGURE 13: SERVICE AREA OF ORIGIN OF GRC RESIDENTS AND THOSE AWAITING GRC PLACEMENT BY PLANNING GROUP AND AGE. 39

FIGURE 14: SUMMARY OF CHARACTERISTICS OF COMMUNITY CLIENTS. 41

FIGURE 15: COMMUNITY CLIENTS AND PERSONS ON WAITING LIST BY PLANNING GROUP. 43

FIGURE PAGE

FIGURE 16: PERSONS AWAITING COMMUNITY RESIDENTIAL SERVICES BY SERVICE AREA, PLANNING GROUP, AND AGE. .45

FIGURE 17: PERSONS AWAITING DAY SERVICES BY SERVICE AREA, PLANNING GROUPS AND AGE. 46

FIGURE 18: CURRENT COMMUNITY CLIENTS BY PLANNING GROUP, SERVICE AREA AND AGE. 47

FIGURE 19: COMPARISON OF FOUR STUDY POPULATIONS USING ICAP PROFILES. 49

FIGURE 20: STUDY SUBPOPULATIONS: AGES 0-5 YEARS. . . .51

FIGURE 21: STUDY SUBPOPULATIONS: AGES 6-21 YEARS. . . 51

FIGURE 22: STUDY SUBPOPULATIONS: AGES 22+ YEARS. . . .52

FIGURE 23: STUDY SUBPOPULATIONS: ALL AGES. 52

FIGURE 24: NUMBER SERVED IN DAY AND RESIDENTIAL SERVICES BY RESPONDENT AGES TO PROVIDER SURVEY. . . .57

FIGURE 25: 22 SERVICE TYPES BY SOURCE OF SERVICE. . . .59

FIGURE 26: TIME TAKEN TO RECRUIT DAY SERVICES STAFF. . 62

FIGURE 27: TIME TAKEN TO RECRUIT RESIDENTIAL SERVICES STAFF. .62

FIGURE 28: TIME TO RECRUIT SUPERVISORY STAFF. 63

FIGURE 29: EXPERIENCE OF NEW RESIDENTIAL STAFF. 64

FIGURE 30: EXPERIENCE OF NEW DAY STAFF. 65

FIGURE 31: TRAINING DAYS OFFERED DIRECT CARE STAFF. . .66

FIGURE 32: CITED TRAINING NEEDS. 67

FIGURE 33: QUALITY REVIEW PROCEDURES EMPLOYED. 69

FIGURE 34: TYPES OF INFORMATION AVAILABLE TO LOCAL PROGRAM MANAGERS. 70

FIGURE 35: SUGGESTIONS FOR IMPROVED CASE COORDINATION. 71

FIGURE 36: COMMUNITY ACCEPTANCE. 72

FIGURE PAGE

FIGURE 37: COMMUNITY REACTION TO ESTABLISHMENT OF RESIDENTIAL PROGRAMS. 73

FIGURE 38: IMPACT OF LOCAL ZONING REGULATIONS. 74

FIGURE 39: PRIORITIES FOR SERVICE EXPANSION. 75

FIGURE 40: OVERALL DIFFICULTY WITH OBTAINING SIX MEDICAL SERVICES. 86

FIGURE 41: OVERALL DIFFICULTY WITH OBTAINING 11 SUPPORT SERVICES. 88

FIGURE 42: OVERALL DIFFICULTY WITH OBTAINING FIVE CARETAKER SUPPORTS. 90

FIGURE 43: STAFF PROJECTIONS. 91

FIGURE 44: LABOR RESOURCES. 92

FIGURE 45: UNEMPLOYMENT RATES IN SEVEN TARGET AREAS. . 94

FIGURE 46: FAMILY CONCERNS. 122

FIGURE 47: FAMILY CONCERNS BAR GRAPH. 124

TABLE OF CONTENTS

PART TWO

Page

I. WHAT SYSTEM CHANGES WILL BE REQUIRED? 1

A. Administration. 1

1. Expand Private Sector Involvement. 2
2. State Management Responsibilities. 3
3. Data Management. 3
4. Local Resource Development. 4

B. Quality Assurance. 4

1. Standards. .5
2. Licensing. .6
3. Monitoring. 7
4. Client Rights. 7

C. Family Involvement. 8

D. Community Acceptance and Zoning. 9

1. Community Acceptance. 9
2. Zoning. 11

E. Medical Back-Up Services. 12

F. Crisis Support Services. 14

G. Interagency Collaboration. 14

1. Department of Education. 15
2. Department of Medical Assistance. 15
3. State Health Planning and Development Agency. 15
4. Office of Regulatory Services. 16
5. Title V Program. 16

II. WHERE WILL THE STAFF COME FROM?. 17

A. Acquiring Needed Staff. 17

  1. Direct Care Staff. 17
  2. Supervisory Staff. 22
  3. Specialized Habilitative Staff. 24
  4. Medical Services. 25

B. Additional Considerations. 25

  1. Development of a Community Based Human Services Industry. 26
  2. Staff Development. 26

III. WHAT SERVICES WILL BE REQUIRED TO MEET THE NEEDS OF PERSONS IN THE TARGET POPULATIONS AND OTHER POPULATIONS OF CONCERN AND WHAT WILL THEY COST?. 29

A. Projected Demand. .29

  1. Base Data and Assumptions. 29
  2. Projections. 30

B. Projected Annual Service Requirements and Costs. 33

  1. Base Data. 34
  2. Projections. 43

C. Start-Up Costs. 46

  1. Service-by-Service Analysis. 46
  2. Projections. 56

D. Capital Costs. 59

  1. Base Data and Assumptions. 59
  2. Projections. 61

IV. WHERE WILL THE MONEY COME FROM?. 64

A. One-Time Cost of Transition. 64

B. Start-Up Costs. 65

C. Operating Costs. 65

D. Capital Costs. 68

  1. Federal Sources. 68
  2. Private Sources. 71

V. HOW SHOULD THE TRANSITION BE MANAGED, HOW MUCH WILL IT COST, AND HOW LONG WILL IT TAKE?. 72

A. Project Management. 72

  1. Discussion. 72
  2. Budget Estimates. 75

B. Resident Preparation/Relocation and Follow-Up. . . 75

VI. IMPLEMENTATION: ELEMENTS AND TIMING 81

A. Phase One -- Strategic Planning 81

B. Phase Two -- Legislative Actions 82

C. Phase Three -- Implementation Planning 82

D. Phase Four -- System Development 83

E. Phase Five -- Program Start-up and Operation . . . 84

LIST OF FIGURES: PART TWO

FIGURE PAGE

FIGURE 1 : RELATIVE UNEMPLOYMENT RATES IN NORTHERN AREAS. 20

FIGURE 2: STUDY SUBPOPULATIONS BY AGE AND LEVEL OF FUNCTIONING - 1987 31

FIGURE 3: STUDY SUBPOPULATIONS BY AGE AND LEVEL OF FUNCTIONING - 1992 32

FIGURE 4: WEEKLY HOURS OF STAFF TIME PER CLIENT BY TYPE OF PROGRAM AND PLANNING GROUP . . .40

FIGURE 5: PROJECTED SERVICE DEMAND AND COSTS BY SERVICE CATEGORY, BY TARGET SUB-POPULATION AND OTHER POPULATIONS OF CONCERN: 1987 AND 1994 44

FIGURE 6: ICF/MR SMALL (NEW) START-UP COSTS 49

FIGURE 7: GROUP HOME START-UP COSTS 50

FIGURE 8: STAFFED SUPERVISED APARTMENT START-UP COSTS 52

FIGURE 9: SHELTERED WORK START-UP COSTS 53

FIGURE 10: SUPPORTED EMPLOYMENT START-UP COSTS. 55

FIGURE 11: MEDICAL SUPPORT UNIT START-UP COSTS. 56

FIGURE 12: CRISIS SUPPORT START-UP COSTS 57

FIGURE 13: PROJECTED PROGRAM START-UP COSTS BY TYPE OF PROGRAM AND STUDY SUBPOPULATION 58

FIGURE 14: PROJECTED PROGRAM CAPITAL COSTS BY TYPE OF PROGRAM AND STUDY SUBPOPULATION 62

LIST OF APPENDICES

APPENDIX A: REFERENCES

APPENDIX B: INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP)

APPENDIX C: GEORGIA FAMILY SURVEY

APPENDIX D: COMMUNITY PROVIDER SURVEY

APPENDIX E: SAMPLE STANDARDS FOR SOUTH CAROLINA FACILITIES SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES

APPENDIX F: PROJECTED SERVICE REQUIREMENTS AND COSTS BY TYPE OF SERVICE AND CLIENT LEVEL OF FUNCTIONING

APPENDIX G: PROPOSED MODEL FOR IOWA STATE-WIDE STAFF TRAINING OF DIRECT-CARE STAFF

APPENDIX H: RESIDENTIAL FACILITIES: ARCHITECTURAL DESIGNS AND ESTIMATED COSTS

APPENDIX I: STEERING COMMITTEE MEMBERS

PART ONE

I. INTRODUCTION

The following report was commissioned by the State of Georgia to explore the feasibility of serving persons currently living at Georgia Retardation Center (GRC) and the Southwestern Developmental Center at Bainbridge in alternative community living and daytime arrangements. The subsequent project was governed by a series of assumptions:

- Alternative services must be equivalent or better than those currently provided to persons at GRC and Bainbridge.
- Services should be provided in the least restrictive setting.
- Any transition should be accomplished with the minimum disruption to clients as well as staff.
- Community services should provide maximum opportunities for integration and individualization.
- Family members should be given every opportunity to participate in the planning on behalf of clients and in the monitoring of service provision.
- Each client's plan for alternative services should be reflective of his or her unique needs and strengths.
- Funds made available from the phase-out of the two facilities should be made available to the development and ongoing maintenance of alternative services.
- The phase down of GRC and Bainbridge should provide an opportunity to make changes in the general system of services that will ultimately benefit clients beyond the immediate target population.

With respect to the specific mandate of this project, HSRI has assumed from the outset that the objective was not to determine whether these two institutions should be closed nor to pass judgment on the virtues of deinstitutionalization as a policy, but rather to determine for the state under what circumstances such deinstitutionalization would be feasible.

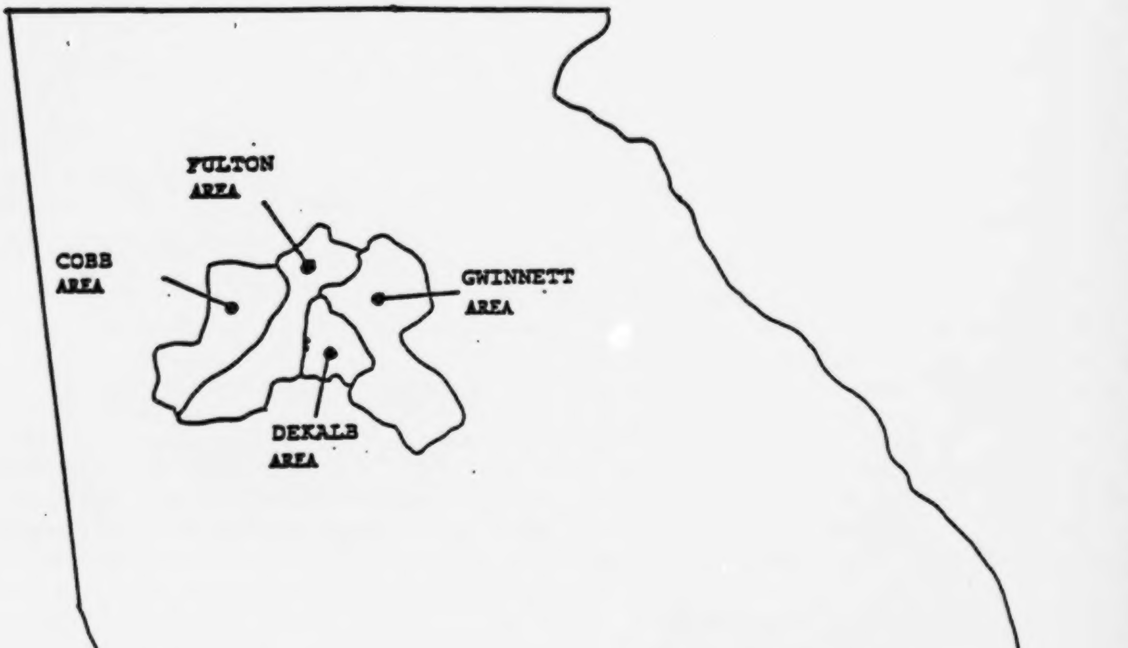
The report that follows is divided into two parts. Part One describes the current service context and outlines the areas that must be addressed in any feasibility examination. Specifically, Part One outlines the study methodology, describes the target population and target facilities, assesses the components of the community and state system, reviews the characteristics of service personnel, and raises the systemic issues that must be taken into account in any institutional phase down. Part Two portrays the activities that should be pursued in order to make the institutional phase-down feasible. The section includes a series of recommended policy and statutory changes, recommends strategies for personnel recruitment and retention, describes the services that will be required to meet the needs of the target population and the costs of those services, suggests sources of funding for such services, proposes a transition strategy, and lays out an implementation schedule.

II. PROJECT METHODOLOGY

A. Introduction

At the time of this study 565 persons were living at the Georgia Retardation Center and Southwestern Developmental Center at Bainbridge. To assess the feasibility of placing these persons into community settings, consensus must first be reached regarding where these persons might be placed, a decision that would greatly influence any such assessment. Examination of each of these person's "county of origin" reveals that most were placed into these two residential centers from seven mental retardation, and substance abuse service areas. This factor, along with the time and resource constraints associated with this study, prompted the project team to focus on a limited number of Georgia's mental retardation service areas, though several project activities involved the entire state. Thus, with the assistance of staff at the Division of Mental Health, Mental Retardation and Substance Abuse, seven areas were chosen for intensive review: Cobb/Douglas, Thomas, Dougherty, DeKalb, Gwinnette, Fulton and Lowndes. As shown by Figure 1, four of these areas lie in north Georgia near GRC, while three are in south Georgia near Bainbridge.

FIGURE 1: SEVEN SELECTED PROGRAM AREAS


FULTON AREA
COBB AREA
GWINNETT AREA
DEKALB AREA
DOUGHERTY AREA
THOMAS AREA
LOWNDES AREA

A variety of methods were used to gather the information needed to achieve the goals and objectives of this project. The four major strategies include:

- ***Site visits.*** To become acquainted with the present service system in Georgia, project staff visited community programs in the seven selected areas as well as GRC and Bainbridge;

- ***Systematic surveys.*** Three surveys were undertaken to obtain quantitative data relevant to the planning process, including surveys of: 1) persons with mental retardation using the Inventory for Client and Agency Planning (ICAP), 2) community service providers throughout the state, and 3) family members of persons residing at GRC and Bainbridge;

- ***Key-informant interviews.*** A great many people in Georgia were interviewed to obtain information about the current system including: parents, advocates, state officials, service providers, and other citizens in Georgia; and

- ***Review of existing records.*** Project staff gathered and reviewed existing documents, records and legislation in Georgia that are relevant to this study (e.g., zoning codes, fire/safety codes, past planning reports). Additionally, staff obtained reports regarding the efforts undertaken in other states to phase out institutional programs.

Figure 2 displays the key objectives of the study and the means used to collect needed information. As shown, certain data collection activities provided information relevant to multiple objectives, while others had a single purpose. In the following sections, the means used to collect information are described in greater detail.

FIGURE 2: KEY PROJECT OBJECTIVES BY DATA COLLECTION STRATEGY.

PROJECT OBJECTIVE	SITE VISITS	SYSTEMATIC SURVEYS			KEY INFORMANT INTERVIEWS	REVIEW OF RECORDS	
		ICAP SURVEY	PROVIDER SURVEY	FAMILY SURVEY		GEORGIA RECORDS	OTHER RECORDS
PREPARE CLIENT PROFILES	X	X	X				
ZONING ANALYSIS	X		X			X	
ANALYSIS OF SERVICE DEMAND		X					X
ANALYSIS OF COMMUNITY SUPPORT	X		X	X	X		
ANALYSIS OF STAFF AVAILABILITY	X		X		X	X	
ANALYSIS OF SYSTEM MANAGEMENT	X		X		X		
ANALYSIS OF SERVICE CAPACITY	X		X				
PROVIDER CAPABILITY ASSESSMENT	X		X		X		
ASSESSMENT OF PROVIDER STABILITY	X				X		
SYSTEM MANAGEMENT DESIGN	X	X	X		X		
SERVICE MODEL DESIGN	X	X	X	X	X		
FACILITY DESIGN		X			X		X
ASSESSMENT OF STAFFING REQUIREMENTS	X		X		X	X	X
ANALYSIS OF START-UP COSTS		X			X	X	X
ESTIMATE CAPITAL COSTS		X			X	X	X
ESTIMATE ONGOING COST		X			X	X	X
DESIGN OF QUALITY ASSURANCE PROVISIONS	X		X		X	X	X
PREPARING A TRANSITION PLAN		X			X		X

B. Surveys of Persons with Mental Retardation and Other Developmental Disabilities

The target populations in this study are:

- *Individuals currently residing at the Georgia Retardation Center (GRC);*
- *Individuals awaiting placement at GRC; and*
- *Individuals currently residing at the Southwest Developmental Center at Bainbridge.*

It is these individuals for whom community-based service alternatives would have to be developed. Two other populations of concern in this study are:

- ***Individuals currently being served in the community.*** **An assessment of the level of functioning of current clients provides an appreciation of the existing community service capacity and the extent of experience in serving individuals with disabilities similar to those at GRC and Bainbridge; and**

- ***Individuals awaiting service in the community.*** **The needs of these individuals must be given due consideration in the name of equity and to ensure that the increased service demands resulting from the outplacement of individuals from GRC and Bainbridge does not jeopardize their interests.**

1. Classifying Individuals by Level-of-Functioning

The issue under consideration is the provision of community-based services to current residents of Georgia Retardation Center and Southwest Developmental Center at Bainbridge and to persons currently awaiting placement at GRC. Also under consideration is the possible provision of services to others awaiting services in the target community. Because the type and intensity of services required depends in large part on the level of functioning of the persons served, an effort was made to identify the level of functioning of residents and persons waiting for placement.

There are a variety of methods for identifying and classifying persons with developmental disabilities. The purpose of these methods may be: 1) to help pinpoint an individual's eligibility for services; 2) to guide individualized program planning; or 3) to provide a foundation for system-level, strategic planning. The classification scheme described herein is designed expressly for the latter purpose.

As part of the HSRI strategic planning model, individuals are classified into ten levels of functioning or planning groups. Specifically, HSRI uses a standard classification scheme to assign persons with developmental disabilities to various groups and subgroups for modeling purposes. This scheme is designed to encompass the vast majority of persons with mental retardation and other developmental disabilities.

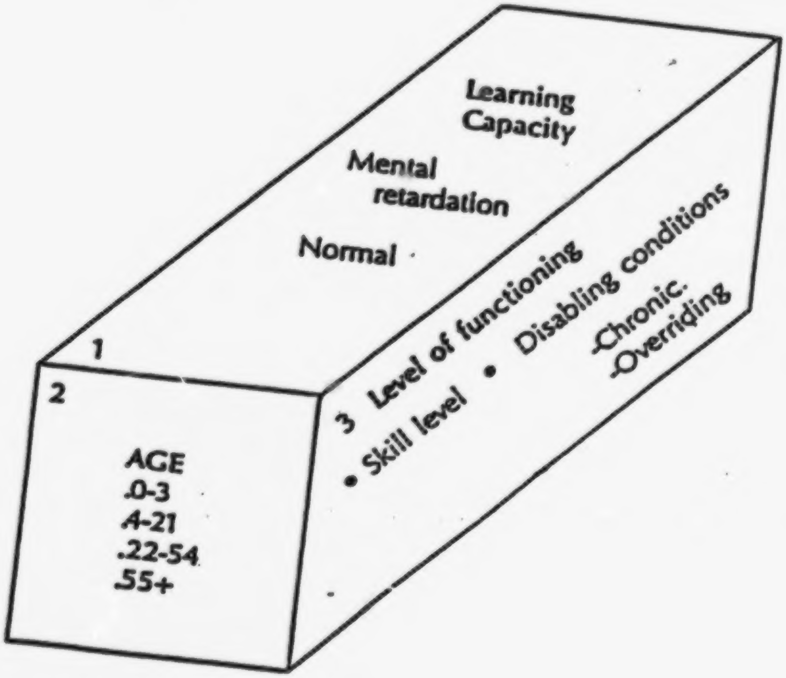
a. Classification Scheme

In order to estimate and plan for aggregate service needs, criteria first must be established for dividing individuals into a comprehensible number of groups -- each group sharing key characteristics related to

service needs and probable effects of these services on level of functioning. Using this information, the types, amounts and costs of required services can be projected, and cost-effective plans may be formulated for acquiring needed resources.

HSRI's classification system is designed to maximize the difference among subpopulations of persons with developmental disabilities in terms of the types and levels of services they require currently and the probable effects of these services on their level of independence (functioning). As illustrated in Figure 3 individuals are classified along three axes: (1) learning capacity, (2) age, and (3) level-of-functioning. Their level-of-functioning is a product of their demonstrated skill level, and the type and severity of any extraordinary disabling conditions

FIGURE 3: STRATEGY FOR CLASSIFYING PERSONS WITH DISABILITIES


Learning
Capacity
Mental
retardation
Normal
1
2
AGE
.0-3
.4-21
.22-54
.55+
3 Level of functioning
• Skill level • Disabling conditions
-Chronic.
-Overriding

b. Learning Capacity

Learning capacity refers to the ability of individuals to recognize auditory or visual stimuli as a basis for communicating, to understand and retain this information for future application, and to generalize and conceptualize from experience (to reason). Learning capacity dictates the extent to which certain levels of instruction will yield the acquisition of new skills. One would expect persons with no mental retardation to progress more rapidly than those with mental retardation (all other capacities the same)

c. Age

Regardless of whether an individual's pattern of development is normal, his or her level of functioning is affected by age. All children up to 36 months of age are invariably found at the lowest skill level -- skill level IV. However, as normal children grow older and their ability to perform daily living skills grows their need for supervision and support typically declines. Though individuals with mental retardation may require higher levels of supervision throughout their lives, the character of such supervision also changes with developmental milestones. In fact, a number of different service/cost patterns may be observed as a function of the type of disability and age.

d. Level of Functioning

1) Skill Level

Individuals are assigned to one of four skill levels reflecting their relative ability to function independent of special supervision and supports. For purposes of the Feasibility Study, the four supervision requirements associated with these skill levels as defined by the Division of Mental Health, and Mental Retardation and Substance Abuse, are shown below:

- ***LEVEL 1*** - Intermittent, minimal training and/or supervision in advanced community living skills to promote increased independence.

- *LEVEL II* - A moderate degree of daily training and/or supervision with this phase, including certain advanced skills, and with some attention focused on basic self-help skills;

- *LEVEL III* - A major degree of and/or supervision with many skill domains, with focus on the refinement of basic self-care skills such as toileting and dressing; and

- *LEVEL IV* - An intense degree of training in supervision of (and/or direct, physical assistance with) almost every skill domain with the additional consideration that persons needing this intensive degree of assistance have secondary handicapping conditions, such as extreme behavior disorder, serious medical problems or extraordinary debilitating physical anomalies.

2) Extraordinary Disabling Conditions

Persons with developmental disabilities may possess a number of disabling conditions that affect skill performance and that demand specialized services and support. These conditions include:

- *Medical complications* -- characterized by medical conditions severe enough to demand continued medical attention from medically trained personnel;

- *Physical impairments* -- characterized by the absence of voluntary muscle control over one's extremities (i.e., head, arms, legs) or the absence of arms or legs;

- *Sensory impairments* -- characterized by a severe handicapping condition pertaining to the senses (i.e., hearing, vision); and

- *Challenging behavior* -- characterized by behavior that poses a significant threat to the life or well-being of oneself, other persons or living creatures, or that is destructive of valuable property.

The above disabling conditions are chronic and may be overriding. They are considered *chronic* if they can be expected to persist for at least one year on a continuous basis. With special support, however, individuals with chronic conditions are able to perform self-care and/or other daily living skills and learn new skills at a rate comparable to others at their designated skill levels having no such conditions.

In contrast, these conditions are considered *overriding* if they prohibit or substantially inhibit individuals from performing self-care and/or other daily living skills which in turn necessitates the provision of intensive remedial services or supports to manage or ameliorate the conditions.

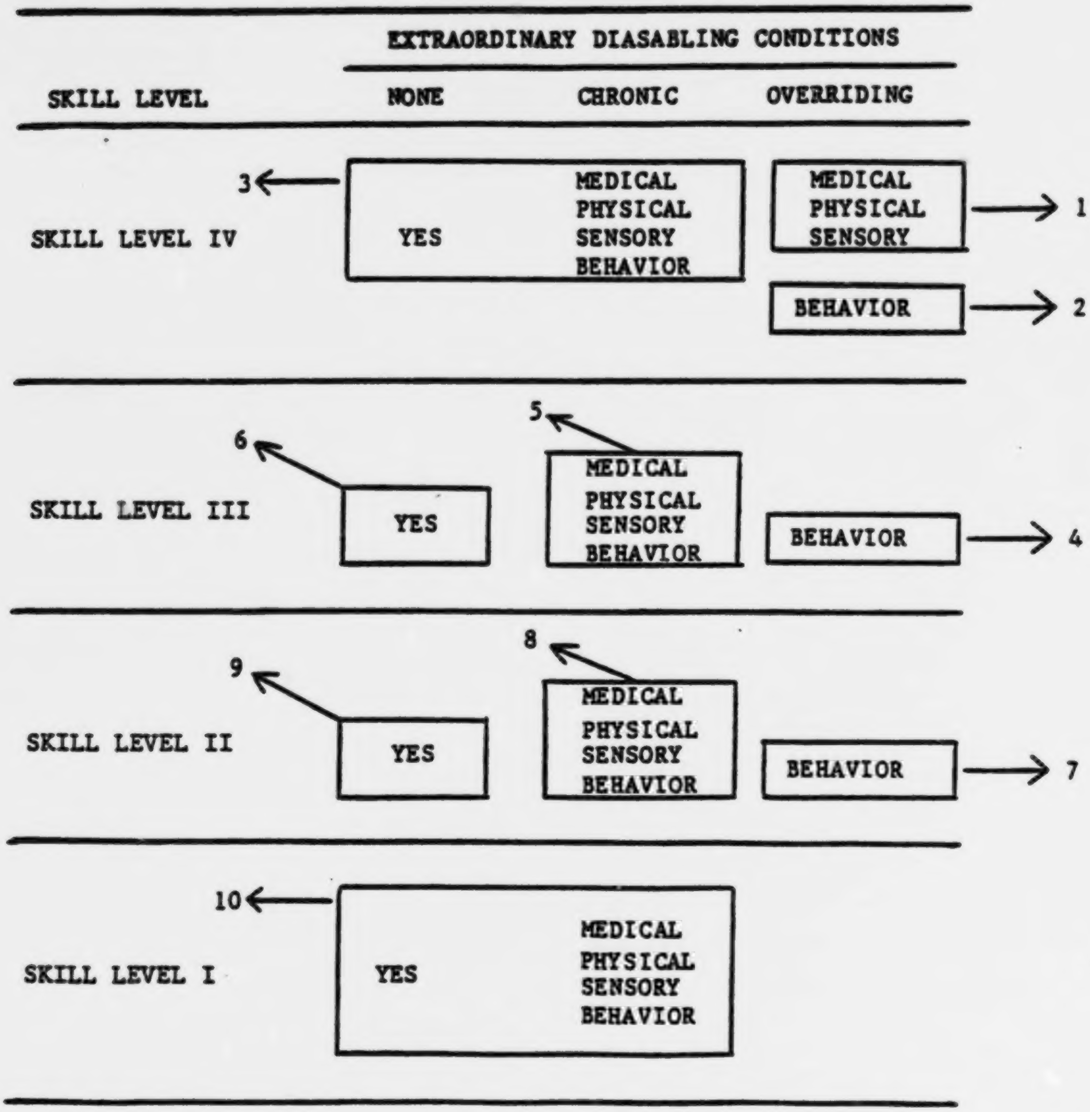
The majority of persons with overriding medical/physical disabling conditions have had little or no opportunity to learn most self care and daily living skills or have contracted conditions so debilitating that even when the conditions are no longer overriding, they cannot be expected to move beyond the highly dependent level (fourth skill/supervision level) without considerable training. On the contrary, overriding behavioral conditions can be found among individuals in the highly dependent (IV) to the semi-independent (II) skill levels. Once these maladaptive behaviors are brought under control these persons can be expected to return to their original skill levels.

In sum, an overriding disabling condition is one that has not been ameliorated and is so severe that it dominates a person's life, severely restricting the individual's capability to perform daily living skills.

e. Planning Groups

The matrix in Figure 4 shows that when skill/supervision levels are combined with overriding and chronic conditions, 10 planning groups result. Persons with mental retardation or other developmental disabilities may be assigned to any one of these ten planning groups. As shown in Figure 4, in grouping persons into the ten planning groups, persons with no chronic disabilities are classified separately from persons with chronic disabilities at skill levels II and III but not at skill levels I and IV. (By definition, persons at skill level IV lack self care skills and thus demand a level of supervision and support so heavy that the presence or absence of extraordinary chronic medical, physical, sensory or behavior problems is relatively insignificant in terms of current and potential levels of functioning and service demand.) Similarly, by definition, persons at skill level I are able to function largely free of programmed supervision and support and thus the differences in services demanded between persons at skill level I with chronic disabilities and without are not significant. On the other hand, persons at skill levels two and three with chronic medical, physical, sensory and/or behavior problems, can be expected to demand an extra measure of supervision and support beyond that demanded by persons without these chronic disabilities.

FIGURE 4: TEN PLANNING GROUPS FOR PERSONS WITH MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES


EXTRAORDINARY DIASABLING CONDITIONS
SKILL LEVEL
NONE
CHRONIC
OVERRIDING
SKILL LEVEL IV
3
YES
MEDICAL
PHYSICAL
SENSORY
BEHAVIOR
MEDICAL
PHYSICAL
SENSORY
1
BEHAVIOR
2
SKILL LEVEL III
6
YES
5
MEDICAL
PHYSICAL
SENSORY
BEHAVIOR
BEHAVIOR
4
SKILL LEVEL II
9
YES
8
MEDICAL
PHYSICAL
SENSORY
BEHAVIOR
BEHAVIOR
7
SKILL LEVEL I
10
YES
MEDICAL
PHYSICAL
SENSORY
BEHAVIOR

When considering these categories, it should be noted that to meet the definition for developmental disabilities, all persons without extraordinary disabling conditions must have mental retardation. Similarly, in order to meet the definition of developmental disabilities, persons without mental retardation at skill level I, must have an extraordinary disabling condition.

f. Individual Assessments

Assessing the level-of-functioning of persons with mental retardation and other developmental disabilities requires multidimensional measures, commonly termed scales or indexes. An index is constructed through a simple accumulation of scores assigned to individual attributes. These scales or indices range from those comprised of hundreds of questions (criteria or anchor points) specific to particular self-care, adaptive, and independent living skills and to particular maladaptive behaviors to those comprised of general questions (loosely defined as anchor points). For our purposes, the former measures are termed "composite" measures and the latter, "global" measures.

Composite measures based on a number of specific criteria are much easier to interpret than are global measures. Though composite measures are just as dependent on personal judgment as global measures, the basis for that judgment is more explicit. The assessor's attention is directed toward specific functional dimensions, and the extent to which these dimensions have been realized (e.g., the ability to walk with the aid of a cane).

There are many composite measures that have been developed, tested and used to gauge the level of functioning of persons with mental retardation and other developmental disabilities. HSRI and others using this classification strategy have devised scoring protocols for a number of the more widely used instruments, including the Inventory for Client and Agency Planning (ICAP) used in this study.

2. Data Collection Using the Inventory for Client and Agency Planning (ICAP)

To appreciate the functioning capabilities and service needs of persons at GRC and Bainbridge, assessments were made using a standardized measure.

For comparative purposes, and in order to determine the availability of community-based services, clients on the GRC waiting list and additional samples of persons with mental retardation living in community-based settings in the seven target mental retardation service areas were assessed as well. Figure 5 lists each target sample and the number of persons assessed.

FIGURE 5: PERSONS ASSESSED USING THE ICAP BY SAMPLING PROCEDURE

Group	N	Sampling Procedure
GRC	369	All clients in service
GRC waiting list	70	All clients
Bainbridge	196	All clients in service
Fulton	21	Selected randomly from 3 service centers and 1 residential program list
Gwinnette	15	Selected randomly from residential clients
DeKalb	30	Selected randomly from residential clients
Cobb	260	All clients in service
Lowndes	167	Selected randomly (about 50% of all clients)
Dougherty	140	Selected randomly (nearly all clients)
Thomas	15	Selected randomly from residential clients

Note: Residential services include all models, foster and support families.

The assessment measure. Clients were assessed by residential facility staff or by case managers using the *Inventory for Client and Agency Planning* (ICAP). The ICAP is an assessment booklet that gathers basic demographic information about the person being assessed (client), as well as information about diagnoses, health and mobility, adaptive and maladaptive behavior, services received, services needed, and family/social activities. This combination of items makes the ICAP very suitable for management information and planning purposes. A copy of the ICAP is attached as Appendix B.

ICAP items were standardized in a manner that makes them clear to a variety of respondents, resulting in high reliability. The ICAP manual (Bruininks, Hill, Weatherman & Woodcock, 1985) describes numerous studies demonstrating split-half reliability, test-retest reliability, and inter-rater reliability near or above r=.90 for adaptive behavior items, and in the .80's for maladaptive behavior. The ICAP discriminates well among clients in various residential and habilitation programs.

The ICAP was normed on a national representative sample of approximately 1,700 people. Supplemental data were gathered on over 2,000 persons with disabilities. A unique feature of the ICAP is its Service Index, an overall "level of need" score based upon both adaptive and maladaptive behavior. Normed sections of the ICAP can be scored by hand with the use of scoring tables, or by computer using the ICAP Scoring and Database Program. Training sessions on the administration, scoring and interpretation of the ICAP were conducted at GRC and Bainbridge during the first week of June, 1987. Professional staff, unit directors, and case managers from DeKalb, Fulton and Gwinnette services areas (where persons on the GRC waiting list resided), attended these sessions. All GRC, GRC waiting list, and Bainbridge clients were assessed by or with the assistance of these staff during the month of June. Each unit (usually one or two buildings) at GRC and Bainbridge has a professional team (e.g., QMRP, psychologist, social worker, nurse). ICAPs were completed under the direction of team leaders by team members or by direct care staff. In most cases, team members reviewed appropriate sections of completed ICAPS for accuracy and completeness. Staff of the Georgia Department of Human Resources coordinated collection of data on waiting list clients, for whom case managers, often with the assistance of parents or other staff completed ICAPs.

In Fulton, Gwinnette, Dekalb, and Thomas service areas, ICAPs were completed on a sample of clients by their case managers, again sometimes with the assistance of parents or service providers.

ICAP data on clients from the Cobb, Lowndes, and Dougherty areas had been collected earlier in the year in a pilot project conducted jointly by the Georgia Department of Human Resources and the University of Georgia UAP. The pilot project involved training similar to that provided at GRC and Bainbridge.

Completed ICAP booklets were mailed to project staff based at the University of Minnesota. Data were edited for completeness and logical consistency and entered onto a microcomputer using the ICAP software. Respondents (whose names and phone numbers were recorded on the ICAP booklets they completed) were telephoned for clarification regarding any questions that arose during editing. Relatively few questions arose.

After data entry, computer generated ICAP reports were mailed back to respondents for all clients. Data for the Cobb, Lowndes, and Dougherty areas were edited and entered into the ICAP computer program by staff from the Georgia UAP pilot project. Data for these clients were forwarded to project staff at the University of Minnesota on three computer disks. Analysis of these data was completed using the Statistical Package for the Social Sciences (SPSS) on a mainframe computer at the University of Minnesota.

3. Clients Waiting for Services

Information on the numbers of individuals awaiting residential and day services in the seven mental retardation target service areas was obtained from the Division of Mental Health, Mental Retardation and Substance Abuse. Counts and descriptive information on persons awaiting day services was obtained from the mental retardation service center waiting list reports for the years 1984 through 1986. Summary data were obtained for the years 1984 and 1985. Complete records were obtained on disk for 1986 so that HSRI could classify each individual by age and level of functioning using the classification scheme described earlier.

Information on persons currently awaiting residential services was obtained from a special survey administered by the Mental Retardation Services Section. Again, this information was obtained from disk so that HSRI could classify each individual by age and level of functioning.

C. Site Reviews and Interviews

1. Site Reviews

As noted above, seven MH/MR/SA service areas were chosen for intensive review. These seven areas were Cobb/Douglas, Gwinnette, DeKalb, Fulton, Thomas, Lowndes, and Dougherty. A member of the project team visited each of these areas and carried out the following activities:

- Interviews with key program administrative staff including the developmental services chief, mental retardation specialists, and, in some instances, the mental health, mental retardation and substance abuse director as well as the health officer;
- Visits to residential arrangements during hours when clients were at home;
- Visits to day services during hours when clients were working;

- Conversations with clients regarding their lives in the community; and

- Interviews with community staff.

In addition to site visits to community programs, HSRI staff also visited both GRC and Bainbridge. While at the facility, staff visited a range of living units and day programs; interviewed administrative, professional, and direct care staff; and talked with residents.

2. Key Informant Interviews

In addition to visits to program sites, staff also conducted a series of interviews with key state officials, providers, advocacy group representatives, and other interested individuals. Those interviewed included the following:

1) Staff of the Division of Mental Health, Mental Retardation and Substance Abuse;

2) State Medicaid Officials;

3) Representatives of the State Department of Education;

4) Staff of the Division of Vocational Rehabilitation;

5) Representatives of the Georgia Association for Retarded Citizens, the Downs Syndrome Congress and the Retarded Citizens of Atlanta;

6) Director of the Georgia Advocacy Office;

7) Staff of the Office of Regulatory Services;

8) State Quality Assurance Staff;

9) Representatives of Family and Children's Services; and

10) Program consultants.

Further, staff of the Division of MH/MR and SA convened a meeting of service providers and program administrators from the seven key communities to discuss the current community service delivery system both in terms of strengths and weaknesses.

Finally, staff convened meetings of parents and family members of individuals living at GRC and Bainbridge in order to more clearly understand their concerns and expectations.

D. Family Survey

To gain a better understanding of the perceptions of family members regarding their relatives with mental retardation, a mailed survey was prepared. The respondents were the closest relatives of the people living at Georgia Retardation Center and Bainbridge State Hospital. The questionnaire, which is included in Appendix C of the report, was prepared jointly by Conroy and Feinstein Associates, and the Division of Mental Health, Mental Retardation and Substance Abuse.

The questionnaire asked the family's opinion about the quality of the care received by their relatives, how happy they think their relatives are with their situations, attitudes about major issues in the field, and major concerns. Every effort was made to avoid professional jargon and to use a layperson's vocabulary. There were 27 questions on the survey, and it was designed to take an average of about 15, but never any more than, 30 minutes. The survey packages were mailed out with a cover letter from the Division explaining the purpose of the project, a survey form, and a stamped envelope in which to return the survey form.

As of this writing, the responses from GRC families numbered 194. Out of 402 packages sent out, the GRC response rate is 48.3%. For Bainbridge, 113 responses were received to 188 packages, for a response rate of 60.1%. A full description of the results is included in Section VII, Part One.

E. Provider Survey

Information was collected from administrators of service agencies across Georgia who provide services to persons with mental retardation or other developmental disabilities. The survey process was completed in three steps: 1) design of the survey form, 2) design of a sampling

plan and distribution of the survey forms, and 3) compilation of the information collected.

1. Design of the Survey Form

The survey form was designed to collect information regarding the status of community-based services in Georgia. Four major areas of inquiry were identified and 36 questions were developed. Appendix D contains a copy of the survey form. Descriptions of the four survey domains and the types of questions included within each are as follows:

- ***Background information.*** **This section includes six questions concerning the number and types of persons served, the types of day and residential services provided, the difficulty experienced in securing a variety of support services, and the sources used to acquire these services;**

- ***Program staffing.*** **This section includes 19 questions pertaining to the direct care and supervisory staff employed by the responding agencies, and covers the number of staff employed, compensation, staff recruitment, staffing models, and staff training;**

- ***Agency/Policy operations.*** **This section includes four questions concerning systems for managing information, assuring quality in service provision, and case management; and**

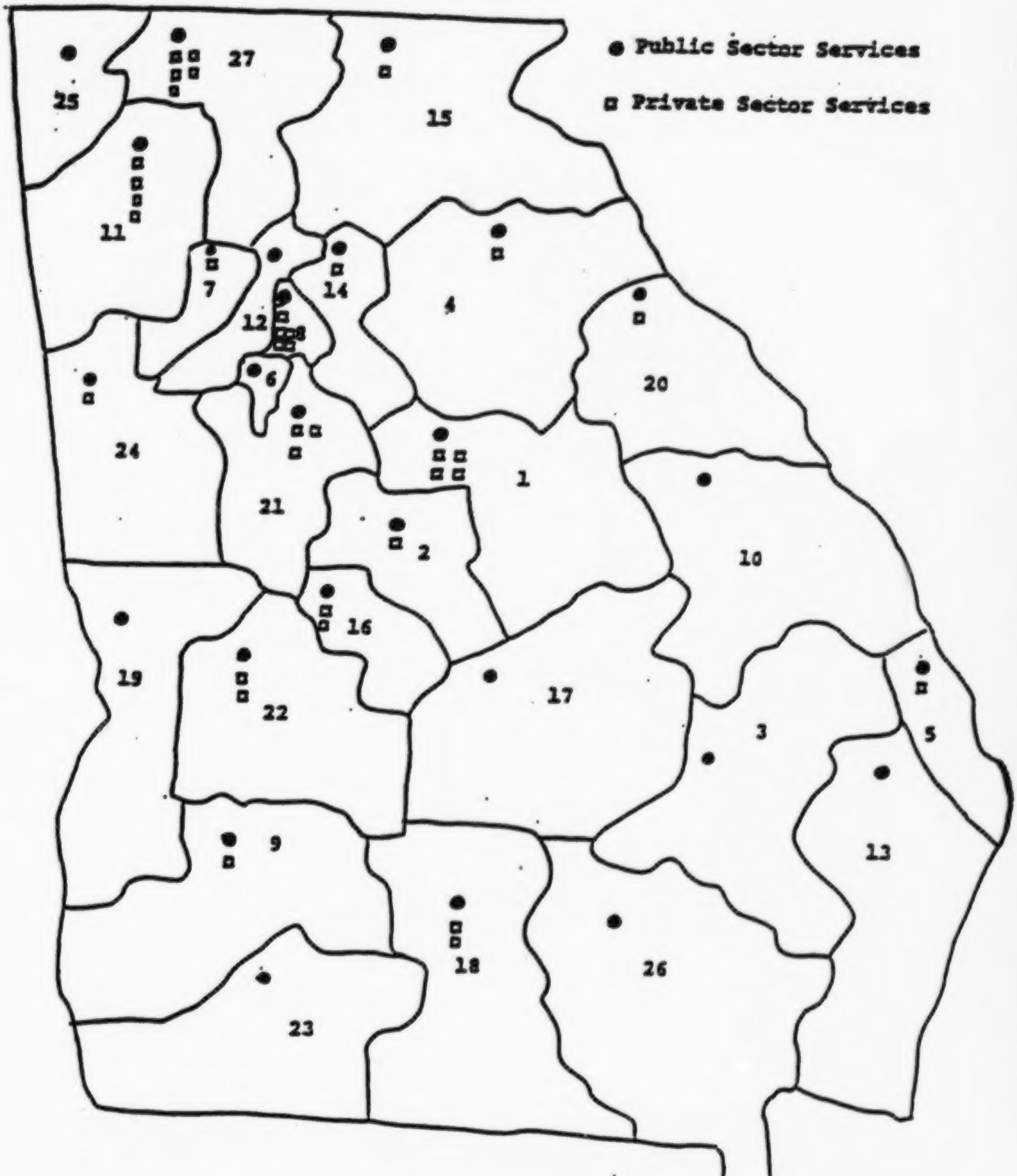
- ***Future directions and community involvement.*** **This final section includes seven questions pertaining to previous efforts to place institutional residents into community programs, public attitudes and potential obstacles regarding the establishment of community programs, and current service priorities.**

2. Sampling Plan and Survey Distribution

To elicit a broad and representative response, 63 survey forms were sent to administrators of services offered through both the public and private sectors. Specifically, forms were sent to administrators at each of the 27 MH/MR/SA areas. The remaining 36 forms were sent to administrators of private non-profit service agencies. These agencies were chosen by staff at the Department of Human Resources, and were selected based on their geographic distribution and diversity.

Respondents were each sent a survey form, along with a letter to describe the purpose of the survey and to urge their participation. Additionally, a prestamped and addressed envelope was included for use by the respondents to return completed survey forms. Figure 6 shows a map of Georgia divided into its 27 program regions and indicates the number of forms distributed in each.

FIGURE 6: SURVEYS DISTRIBUTED BY 27 PROGRAM REGIONS

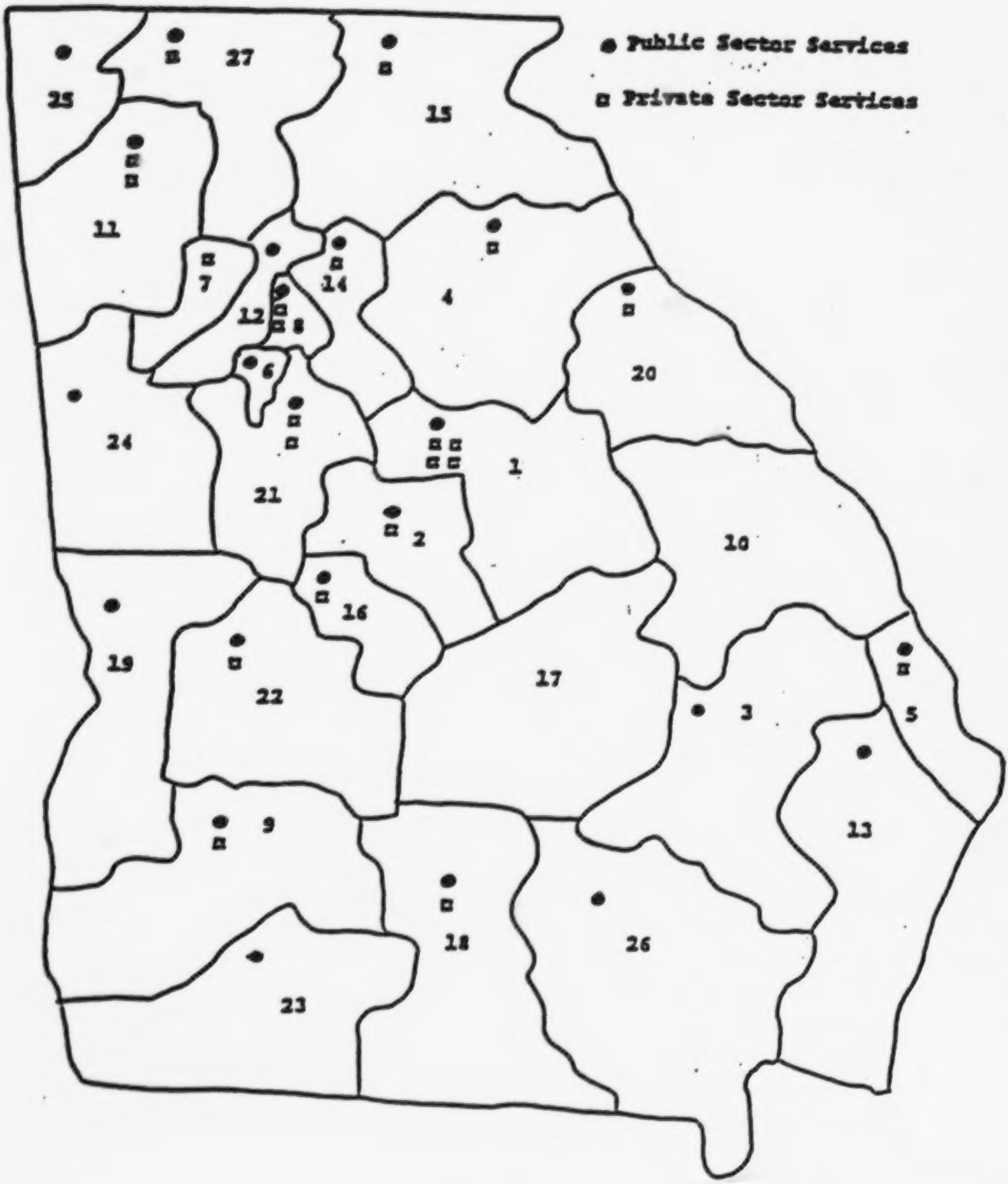

● Public Sector Services
◘ Private Sector Services
25
27
15
11
7
12
8
14
4
20
6
24
21
1
2
10
19
16
22
17
3
5
13
9
18
26
23

3. Compilation of Survey Information

Each of the 63 survey forms was precoded to track return patterns and to simplify the data compilation process. Returned forms were first screened to identify any difficulties the respondent may have had in interpreting the questions. In a few cases, staff at the Division of Mental Health, Mental Retardation and Substance Abuse contacted respondents by phone to clarify certain responses. Subsequently, the information collected was coded and prepared for statistical analysis.

The number of respondents returning survey forms totaled 46 of 63, a response rate of 73.0%. Figure 7 displays the response pattern by the 27 program regions. As shown, responses were received from 24 of the 27 public sector service centers, including representation from six of the seven target areas. Additionally, responses were received from 22 of the 36 administrators of the private non-profit service agencies. Responses were not received from any administrators in two of the program regions.

FIGURE 7: PATTERN OF RETURNED SURVEY FORMS


● Public Sector Services
□ Private Sector Services
25
27
15
11
7
12
8
14
4
20
6
24
21
1
2
10
16
19
22
17
3
5
13
9
18
26
23

F. Manpower Assessment

To support the community placement of present GRC and Bainbridge residents, a great variety of staff will be required. In assessing manpower needs and potential, project staff focused on these four types of staff 1) direct care, 2) supervisory, 3) specialized habilitative (e.g., physical therapists, occupational therapists, speech/hearing therapists, behavior specialists), and 4) medical/health. These four types of staff are essential to the success of any plan to provide community-based services and various parts of the report make reference to their need and availability.

The status of other types of staff was not assessed (e.g., maintenance personnel, cooks, pharmacists). Many of the duties currently performed by these specialty personnel at GRC and Bainbridge will be assumed by community program staff, or by persons or businesses already available in the community.

The assessment of available manpower to staff the additional community-based services required to accommodate the target populations utilized information from four major project activities: review of Georgia records, the community provider survey, key informant interviews and HSRI's Strategic Planning Model.

- ***Review of Georgia records:*** The Georgia Department of Labor provided data on county, regional and state unemployment rates. Local labor departments in the seven targeted communities provided data on the numbers of applicants seeking work in specified occupations during the past month and past year. Other Georgia records were reviewed for information pertaining to the numbers of staff by occupation employed at GRC and Bainbridge, their home counties and to community and institutional comparative salary rates.

- ***Community provider survey:*** The survey included a number of questions aimed at community staffing issues (see the previous section). Data was collected on the types of staff employed, turnover rates, recruitment difficulties and strategies, and general accessibility to professional services. Data was analyzed by the seven target communities, by population density and by regional unemployment rates.

- ***Key informant interviews:*** Numerous telephone interviews provided data on alternate sources of labor. Representatives from three Atlanta metro region Private Industry Councils, Atlanta JTPA, Community college human services programs, and professional organizations discussed labor potential and constraints. On-site interviews provided anecdotal information on the characteristics of staff employed in the state hospitals and communities.

- *Developmental Disabilities Strategic Planning Model (DDSPM):* The DDSPM is a computer-based planning tool designed by HSRI staff to aid in the design of service systems for persons with mental retardation and developmental disabilities The DDSPM was used to calculate the numbers of direct care staff and professional staff needed to provide services according to recommended staff ratios and service utilization rates.

Together, these data were used to assess present staffing capabilities and to project future staff needs and availability, given closure of GRC and Bainbridge.

G. Zoning and Local Code Reviews

To assist staff in assessing constraints to developing and siting residential arrangements in various communities in the state, a number of documents were reviewed including the revised state fire code, local fire and building codes in the seven target program areas, descriptions of court challenges revolving around siting issues, and national reviews of zoning issues and model zoning statutes.

H. Service Utilization and Cost Projections

1. Ongoing Service Requirements and Costs

The Human Services Research Institute employs a computer-based model, the Developmental Disabilities Strategic Planning Model (DDSPM), to project service requirements and operating costs under alternative community-based service approaches.

There are five types of input data that are entered into the Model:

- The current demand for services by client level of functioning;

- The percentage change projected in demand by client level of functioning;

- The proportion of clients projected to utilize different types of services (See Part Two, Section III);

- The projected level of utilization of these services among service users;

- The unit costs of the different types of services.

The demand data -- the first two types of inputs -- are discussed in Subsection II;B; 3. The last three types of inputs are discussed below

Except for their particular handicaps, persons with developmental disabilities are no different than anyone else. All require food, clothing and shelter, and in the event of illness or trauma, they require the services of health practitioners. To the extent that their impairment limits their capacity to care for themselves (self-care skills), move about (mobility skills), and carry on activities of daily living, educational and vocational pursuits, they require supervision and support. At the same time, in the interest and to the benefit of both the individual and society, they should be afforded the opportunity to learn those skills necessary to reduce their dependence on others.

Stated in terms of particular service requirements, this translates into six general classifications of services, each of which contains some number of service subclassifications or types. As shown by Figure 8, 42 types of service make up the complement of services planned for persons in the GRC and Bainbridge service areas. The service nomenclature is an amalgam of services identified in Division of Mental Health, Mental Retardation, and Substance Abuse standards, plans and budgets. Taken together these services represent the complement of services to be offered as an alternative to services at GRC and Bainbridge. These services are listed on the following page.

FIGURE 8: SERVICE TAXONOMY

SERVICE CATEGORIES	SERVICE TYPES
CLIENT MANAGEMENT	DIAGNOSIS & EVALUATION INDIVIDUAL PLANNING & MONITORING CLUSTER MANAGEMENT
RESIDENTIAL ALTERNATIVES	ICF-MR IVA MEDICAL SUPERVISION ICF-MR IVB BEHVR MANAGEMENT ICF-MR III HIGH SUPERVISION GRP HOME IVA MEDICAL SUPERVISION GRP HOME IVB BEHVR MANAGEMENT GRP HOME III HIGH SUPERVISION GRP HOME II MOD SUPERVISION GRP HOME I MIN SUPERVISION SPECIALIZED CARE IV FAMILY MEDICAL CARE III FAMILY SPECIALIZED CARE III FAMILY SPECIALIZED CARE II FAMILY SPECIALIZED CARE I FAMILY INDEPENDENT
DAY PROGRAMS	SEGREGATED PRE-SCHOOL INTEGRATED PRE-SCHOOL WORK ACTIVITY SHELTERED WORK INTEGRATED ADULT SERVICES SUPPORTED EMPLOYMENT
CLIENT SUPPORTS	SPEECH & HEARING THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY CRISES INTERVENTION INDIVIDUAL THERAPY GROUP THERAPY PERSONAL CARE SERVICES TRANSPORTATION
HEALTH SERVICES	PREVENTION/MAINTENANCE HOME HEALTH SERVICES ACUTE CARE
CARETAKER SUPPORTS	STAFF TRAINING FAMILY EDUCATION & SUPPORT LEVEL IV RESPITE LEVEL III RESPITE LEVEL II RESPITE LEVEL I RESPITE

For the purposes of projecting reasonable service utilization levels and costs, HSRI relied as much as possible on empirical data -- Georgia-specific data and data from other states. HSRI is alert to the fact that service utilization rates depend heavily on service availability and programmatic philosophy, and in some cases staff found it necessary to adjust actual service utilization figures in order to bring them to a programmatically acceptable level -- a moderate level. Moderate service plans provide for "active treatment" wherein clients receive formal programs of skill building designed to at least maintain their level of independence (residential and day services). Clients receive health maintenance as well as medical treatment for particular problems (medical services). Additionally, clients receive specialized services designed to help them compensate for chronic and disabling medical, behavioral or physical conditions, and to ameliorate overriding conditions.

2. Change Management and Start-up Costs

Estimates of the one-time costs of managing the transition from institution to community-based services, and of program start-up costs are best derived from experience in other states, HSRI drew from its own consulting experience in several states, and conducted a mail survey of all state developmental disabilities councils and MR/DD authorities and of selected research organizations known to have been involved in like efforts.

HSRI also searched its own library for relevant information. The major sources of information referenced in preparing these estimates are listed in Appendix A.

3. Capital Costs

Prototypical plans and relevant cost factors were prepared for four major residential options, with sub-options as noted:

1. *Apartments (2-3 beds);* renovated buildings for both ambulatory and nonambulatory residents.

2. *Small Group Homes (3-5 beds);* renovated buildings for both ambulatory and nonambulatory residents.

3. *Large Group Homes (6-8 beds);* new construction and renovated buildings for both ambulatory residents.

4. *Small ICF-MR (6 beds);* new construction for both ambulatory and nonambulatory residents.

These residential options are distinguished by standards for administration, care provided, and for physical facilities as established in regulations of the Georgia Department of Human Resources, which in turn relate to the Department's standards for the resident population to be served in each type of setting. Except for the apartment option each type of facility listed above is governed by either the "Minimum Requirements for Group Homes 1974" or the "Rules and Regulations for Intermediate Care Homes" (1976). In addition, since building codes vary from one locality to another, the "Proposed Rules of Safety Fire Commission, Chapter 120-3-21" (1986) are utilized as a conservative standard for this study. This document makes substantial reference to the "Life Safety Fire Code," NFPA 101, 1985 edition. Intermediate Care Facilities are also regulated by the Federal Title XIX standards for accessibility and usability by people physical handicaps.

J. Review of Documents

A wide range of policy materials was reviewed in preparation for this report including state statutes, policy memos, regulations, quality assurance standards, consultant reports, materials from the Developmental Disabilities Council, cost and client data, the state Medicaid waiver application and other pertinent reports and documents.

III. WHO ARE THE TARGET POPULATIONS AND OTHER POPULATIONS OF CONCERN?

A. Target Population

1. Where do they live?

The two primary target populations presently reside at the Southwest Developmental Center at Bainbridge and Georgia Retardation Center (GRC). What follows is a brief description of each facility.

a. Southwest Developmental Center at Bainbridge

Bainbridge is located in Decatur County in South Georgia. It is approximately 40 miles from Tallahassee Florida. The facility admitted its first residents on June 20, 1967. Prior to this, Bainbridge had been the Lynn Air Force Base. In 1966 a supplemental appropriations bill which included $600,000 for setting up the facility as a mental health program was approved. The land on which the State Hospital exists was deeded to the State of Georgia from Decatur County for $1.00. At the time of its opening as a mental retardation facility, it was administratively linked to the Southwest State Hospital at Thomasville. In the late 70's efforts were mounted to separate the mental retardation facility from the mental health hospital, but due to cost factors associated with separating the two units it was deemed not feasible. Some of the administrative costs for Bainbridge, therefore, are integrated into the Southwest State Hospital budget.

SDC currently has 197 individuals living there, all of whom are ambulatory. The campus spreads over 209 acres of land, and includes 23 buildings. The entire facility is certified as an intermediate care unit for the mentally retarded (ICF-MR). There are currently 385 staff at Bainbridge (232 direct care that include behavioral technicians, health service technicians, LPNs, shift supervisors, activity therapists, instructors; 48 professional staff that include doctors, nurses, psychiatrists, social workers, dietitians, unit directors, psychologists, occupational and physical therapists; 34 administrative staff that include secretaries and records personnel; and 70 "other" staff that include security, housekeeping, grounds maintenance and food service). These staff give Bainbridge an overall staff:client ratio of 1.95:1, and direct care staff ratio of 1.18:1. In a study conducted by the State of Nevada, Division of Mental Hygiene and Mental Retardation (1983), the State of Georgia ranked third out of 48 states in the richness of staffing ratios. In a related analysis that was part of the same study, Bainbridge again ranked high in staffing -- 152.5 out of 205 institutions.

b. Georgia Retardation Center

Georgia Retardation Center is located in northern DeKalb County. It sits on 98.4 acres in Chamblee Georgia, and serves 37 north Georgia counties. GRC has four residential units that are ICF-MR certified and serve a total of 286 individuals. There are three additional units that are licensed for Skilled Nursing Care for Persons with Mental Retardation (SNF/MR). There are 94 persons living in the SNF/MR units. Those individuals living in the SNF/MR require more intensive medical services. GRC is accredited by the Accreditation Council for Services for People with Developmental Disabilities (ACDD). GRC has 934 staff (578 direct care, 156 professional, 46 administrative staff, and 154 "other" staff). This translates into a staff:client ratio of 2.46:1, or a direct care staff:client ratio of 1.52:1. GRC was rated even higher in the Nevada study -- 183.5 out of 205 facilities nationwide.

2. Description of the Institutional Population

As noted previously (See Section II;B), persons residing at the Georgia Retardation Center and Bainbridge (SDC) were assessed using the Inventory for Client and Agency Planning (ICAP). Figure 9 presents summary information from these ICAP assessments. As shown, a total of 565 institutional residents were assessed, 369 at GRC and 196 at SDC.

Review of this figure prompts the following observations:

- While 43% (n=158) of those at GRC are non-ambulatory (i.e., use wheelchairs), all Bainbridge residents are ambulatory;
- GRC residents are slightly younger than Bainbridge residents, though the majority in each facility are between 22-39 years old;
- Both GRC (n=103) and Bainbridge (n=43) house persons aged 21 years and younger. These children will require community-based special education services near their new residences once outplaced;

- GRC clients are somewhat more limited in their adaptive behavior than Bainbridge residents, a finding that is likely tied to the number of persons with physical disabilities at GRC;

- The level of mental retardation of persons at GRC and Bainbridge is roughly equivalent. Of those at GRC, 87% are classified as having severe or profound mental retardation, while 81% of the Bainbridge residents are likewise classified;

- Residents at GRC tend to display less challenging behavior than those at Bainbridge. Again, this finding may be explained by the greater number of physical disabilities among those at GRC;

- There is at GRC a significant number (n=94) of persons who receive daily or constant nursing care, while only 14 persons at Bainbridge receive such care. Likewise, a greater proportion of GRC residents (n=63 or 17%) have seizures monthly or weekly than do Bainbridge residents (n=12 or 6%); and

- When average "service scores" are compared, the GRC and Bainbridge residents appear to be quite similar in terms of the overall difficulty of providing care. The average service score at GRC is 31, while at Bainbridge it is 30. This index can yield scores from 1-99, with lower scores indicating greater need for supervision and assistance than higher scores.

Taken together, these data reveal a target population composed mostly of adults, though there are numerous persons of school age, who possess significant limitations in adaptive behavior. The populations at the two institutions, however, should not be considered as identical. Many persons at GRC have medical conditions and/or physical disabilities that must be taken into account when planning for community placement. GRC, unlike Bainbridge, also serves some children under age 6. Though the population are comparable with respect to the "service score index," the *types* of services needed may differ significantly between these two groups.

These data are useful when considered in aggregate. To plan individual plans pertaining to community placement, however, each person must be re-assessed and considered in light of his/her own personal needs.

FIGURE 9: SUMMARY OF CHARACTERISTICS OF RESIDENTS OF GRC AND BAINBRIDGE

ICAP INFORMATION	GRC (N=369)	BAINBRIDGE (N=196)	ICAP INFORMATION	GRC (N=369)	BAINBRIDGE (N=196)
SEX			CURRENT RESIDENCE		
MALE	227	132	PARENTS/RELATIVES	0	0
FEMALE	142	64	FOSTER HOME	0	0
			GROUP HOME	0	0
AGE			NURSING HOME	0	0
0-17 YEARS	54	19	STATE INSTITUTION	369	196
18-21 YEARS	49	24	OTHER RESIDENCE	0	0
22-39 YEARS	234	107			
40-61 YEARS	32	45	FAMILY CONTACT IN MONTH		
62+ YEARS	0	1	YES	165	46
			NO	203	149
MOBILITY					
WALKS	210	196	CURRENT DAY PROGRAM		
NON-AMBULATORY	158	0	NONE	31	0
			SCHOOL	14	11
LEVEL OF MR			DAY ACTIVITY CENTER	52	179
NO RETARDATION	3	0	WORK ACTIVITY CENTER	32	0
MILD	4	5	SHELTERED WORKSHOP-	7	0
MODERATE	31	28	OTHER DAY PROGRAM	233	1
SEVERE	74	65			
PROFOUND	248	95	ADAPTIVE BEHAVIOR		
			SAYS 10 WORDS	102	72
SEIZURE ACTIVITY			INDEPENDENT TOILETING	153	127
NONE/CONTROLLED	228	162	USES 3-4 WORD SENTENCES	89	64
LESS THAN MONTHLY	64	19	DRESSES INDEPENDENTLY	71	69
MONTHLY	31	6	CROSSES STREETS ALONE	24	38
WEEKLY	32	6	WRITES NOTES OR LETTERS	7	3
REQUIRED NURSING CARE			AVERAGE AGE (IN MONTHS)	324	384
LESS THAN MONTHLY	252	105			
MONTHLY	21	74	AVERAGE ADAPTIVE AGE (IN MONTHS)	12	22
WEEKLY	1	3			
DAILY	5	11	AVERAGE MALADAPTIVE SCORE	-10	-23
CONSTANT	89	3			
			AVERAGE SERVICE SCORE	31	30
RECEIVES MEDICATION					
YES	329	156			
NO	40	38			

3. Description of Those on the GRC Waiting List

Persons awaiting placement at the Georgia Retardation Center (N=70) were also evaluated using the ICAP. There is no comparable waiting list at Bainbridge. Summary results of these assessments are displayed in Figure 10 and suggest the following observations:

- The majority of those awaiting placement at GRC are relatively young, with about half aged 21 years or younger;

- Though most can walk, a significant number (N=27 or 39%) are non-ambulatory;

- The great majority (N=58 or 83%) are classified as having either severe or profound mental retardation;

- Relatively few of these persons have significant medical complications, most (N=54 or 77%) have no uncontrolled seizure activity and most (N=57 or 81%) require nursing care less than monthly;

- Though these persons live in a variety of residential settings, most (N=47 or 67%) live with family or relatives;

- A significant number are without any day program (N=18 or 26%); and

- As a group these persons have significant limitations in their capacity to perform adaptive living skills, and require great amounts of supervision and assistance.

FIGURE 10: SUMMARY CHARACTERISTICS OF PERSONS ON THE GRC WAITING LIST

ICAP INFORMATION	GRC WAIT LIST (N=70)	ICAP INFORMATION	GRC WAIT LIST (N=70)
SEX		CURRENT RESIDENCE	
MALE	40	PARENTS/RELATIVES	47
FEMALE	30	FOSTER HOME	4
		GROUP HOME	3
AGE		NURSING HOME	5
0-17 YEARS	18	STATE INSTITUTION	5
18-21 YEARS	18	OTHER RESIDENCE	6
22-39 YEARS	26		
40-61 YEARS	7	FAMILY CONTACT IN MONTH	
62+ YEARS	1	YES	59
		NO	11
MOBILITY			
WALKS	40	CURRENT DAY PROGRAM	
NON-AMBULATORY	27	NONE	18
		SCHOOL	21
LEVEL OF MR		DAY ACTIVITY CENTER	21
NO RETARDATION	0	WORK ACTIVITY CENTER	1
MILD	5	SHELTERED WORKSHOP	0
MODERATE	6	OTHER DAY PROGRAM	8
SEVERE	12		
PROFOUND	46	ADAPTIVE BEHAVIOR	
		SAYS 10 WORDS	18
SEIZURE ACTIVITY		INDEPENDENT TOILETING	17
NONE/CONTROLLED	54	USES 3-4 WORD SENTENCES	16
LESS THAN MONTHLY	4	DRESSES INDEPENDENTLY	11
MONTHLY	1	CROSSES STREETS ALONE	6
WEEKLY	11	WRITES NOTES OR LETTERS	2
REQUIRED NURSING CARE		AVERAGE AGE (IN MONTHS)	291
LESS THAN MONTHLY	57		
MONTHLY	7	AVERAGE ADAPTIVE AGE (IN MONTHS)	14
WEEKLY	2		
DAILY	1	AVERAGE MALADAPTIVE SCORE	-17
CONSTANT	3		
		AVERAGE SERVICE SCORE	27
RECEIVES MEDICATION			
YES	45		
NO	16		

4. Target Populations by Planning Group

As alluded to earlier, client profiles derived through use of a standardized measure such as the ICAP can be used to assign clients to one of the ten HSRI planning groups. Using the ICAP data, Figure 11 shows the numbers of persons assigned to each planning group by target population and age group. As shown by this figure:

- the great majority of clients are assigned to planning group 3, those with significant skill deficits (level IV skill/supervision level);
- relatively few are classified as having overriding behavior problems; and;
- a significant number of persons at GRC are assigned to planning group 1, those with overriding physical and/or medical conditions.

Figures 12 and 13 show the distribution of the target populations by planning group and service area of origin for Bainbridge and GRC waiting list.

FIGURE 11: TARGET POPULATIONS BY PLANNING GROUP AND AGE

CENSUS: AGE BY LEVEL OF FUNCTIONING
GEORGIA RETARDATION CENTER

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	369	90	5	203	2	36	27	0	1	5	0
0-5	7	7	0	0	0	0	0	0	0		
6-21	96	32	0	54	1	8	1	0	0		
22+	266	51	5	149	1	28	26	0	1	5	

WAITING LIST: AGE BY LEVEL OF FUNCTIONING
GEORGIA RETARDATION CENTER

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	70	7	5	50	1	2	1	2	1	1	0
0-5	5	0	0	5	0	0	0	0	0	0	0
6-21	31	2	2	23	0	1	0	1	0	1	0
22+	34	5	3	22	1	1	1	1	1	0	0

CENSUS: AGE BY LEVEL OF FUNCTIONING
BAINBRIDGE

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	196	4	17	133	1	21	11	1	4	4	0
0-5	0	0	0	0	0	0	0	0	0	0	0
6-21	43	1	3	28	0	4	5	0	2	0	0
22+	153	3	14	105	1	17	6	1	2	4	0

FIGURE 12: SERVICE AREA OF ORIGIN OF BAINBRIDGE RESIDENTS BY PLANNING GROUP AND AGE

ALL SERVICE AREAS

AGE:	PLN GRPS TOTAL ALL L-O-F	1 SKL IV OVRDG MED/PHYS	2 SKL IV OVRDG BEHVR	3 SKL IV CHRONIC & OTHER	4 SKL III OVRDG BEHVR	5 SKL III CHRONIC	6 SKL III OTHER	7 SKL II OVRDG BEHVR	8 SKL III CHRONIC	9 SKL II OTHER	10 SKL I OTHER
ALL	196	4	17	133	1	21	11	1	4	4	0
0-5	0	0	0	0	0	0	0	0	0	0	0
6-21	43	1	3	28	0	4	5	0	2	0	0
22+	153	3	14	105	1	17	6	1	2	4	0

THOMAS, LOWNDES & DOUGHERTY SERVICE AREAS

AGE:	PLN GRPS TOTAL ALL L-O-F	1 SKL IV OVRDG MED/PHYS	2 SKL IV OVRDG BEHVR	3 SKL IV CHRONIC & OTHER	4 SKL III OVRDG BEHVR	5 SKL III CHRONIC	6 SKL III OTHER	7 SKL II OVRDG BEHVR	8 SKL III CHRONIC	9 SKL II OTHER	10 SKL I OTHER
ALL	96	3	6	63	0	14	6	1	1	2	0
0-5	0	0	0	0	0	0	0	0	0	0	0
6-21	18	1	0	12	0	1	3	0	1	0	0
22+	78	2	6	51	0	13	5	1	0	2	0

FULTON, COBB-DOUGLAS, DEKALB & GWINNETTE SERVICE AREAS

AGE:	PLN GRPS TOTAL ALL L-O-F	1 SKL IV OVRDG MED/PHYS	2 SKL IV OVRDG BEHVR	3 SKL IV CHRONIC & OTHER	4 SKL III OVRDG BEHVR	5 SKL III CHRONIC	6 SKL III OTHER	7 SKL II OVRDG BEHVR	8 SKL III CHRONIC	9 SKL II OTHER	10 SKL I OTHER
ALL	9	0	0	9	0	0	0	0	0	0	0
0-5	0	0	0	0	0	0	0	0	0	0	0
6-21	1	0	0	1	0	0	0	0	0	0	0
22+	8	0	0	8	0	0	0	0	0	0	0

OTHER SERVICE AREAS

AGE:	PLN GRPS TOTAL ALL L-O-F	1 SKL IV OVRDG MED/PHYS	2 SKL IV OVRDG BEHVR	3 SKL IV CHRONIC & OTHER	4 SKL III OVRDG BEHVR	5 SKL III CHRONIC	6 SKL III OTHER	7 SKL II OVRDG BEHVR	8 SKL III CHRONIC	9 SKL II OTHER	10 SKL I OTHER
ALL	91	1	11	61	1	7	5	0	3	2	0
0-5	0	0	0	0	0	0	0	0	0	0	0
6-21	24	0	3	15	0	3	2	0	1	0	0
22+	67	1	8	46	1	4	3	0	2	2	0

FIGURE 13: SERVICE AREA OF ORIGIN OF GRC RESIDENTS AND WAITING LIST CANDIDATES BY PLANNING GROUP AND AGE

ALL SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	439	97	10	253	3	38	28	2	2	6	0
0-5	12	7	0	5	0	0	0	0	0	0	0
6-21	127	34	2	77	0	10	1	1	0	1	0
22+	300	56	8	171	2	28	27	1	2	5	0

THOMAS, LOWNDES & DOUGHERTY SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	0	0	0	0	0	0	0	0	0	0	0
0-5	0	0	0	0	0	0	0	0	0	0	0
6-21	0	0	0	0	0	0	0	0	0	0	0
22+	0	0	0	0	0	0	0	0	0	0	0

FULTON, COBB-DOUGLAS, DEKALB & GWINNETTE SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	303	60	9	170	2	34	20	2	2	4	0
0-5	11	6	0	5	0	0	0	0	0	0	0
6-21	90	19	2	60	0	8	0	1	0	0	0
22+	202	35	7	105	2	26	20	1	2	4	0

OTHER SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	136	37	1	83	1	4	8	0	0	2	0
0-5	1	1									
6-21	37	15		17	1	2	1			1	
22+	98	21	1	66		2	7			1	

B. Other Populations of Concern

1. Description of Persons Receiving Community-Based Services in the Seven Mental Retardation Service Areas

As was noted previously (See Section II;B), a sample of 648 persons receiving services in community programs was assessed using the ICAP. Figure 14 provides summary information on these persons and shows that:

- The great majority of those assessed are living at home with family members;
- Most are aged between 22-39 years, though 108 are school aged and 12 are over 62 years old;
- Over half (n=372 or 57%) are classified as having moderate to mild retardation;
- Very few require daily or constant nursing care or have seizures monthly or weekly;
- Though these persons are spread among a range of day program options, most attend either a Day Activity Center or Work Activity Center;

Overall, it appears that community programs are serving a diverse group of clients, including a large number persons who are identical to GRC and Bainbridge residents in level of functioning. As a group, however, community clients are less severely disabled and have fewer overriding physical, medical and behavioral problems, especially when contrasted with the population at GRC.

FIGURE 14: SUMMARY OF CHARACTERISTICS OF COMMUNITY CLIENTS

ICAP INFORMATION	COMMUNITY (N=648)	ICAP INFORMATION	COMMUNITY (N=648)
SEX		CURRENT RESIDENCE	
MALE	352	PARENTS/RELATIVES	400
FEMALE	303	FOSTER HOME	47
		GROUP HOME	101
AGE		NURSING HOME	1
0-17 YEARS	70	STATE INSTITUTION	0
18-21 YEARS	38	OTHER RESIDENCE	99
22-39 YEARS	388		
40-61 YEARS	123	FAMILY CONTACT IN MONTH	
62+ YEARS	12	YES	566
		NO	75
MOBILITY			
WALKS	563	CURRENT DAY PROGRAM	
NON-AMBULATORY	58	NONE	41
		SCHOOL	24
LEVEL OF MR		DAY ACTIVITY CENTER	181
NO RETARDATION	10	WORK ACTIVITY CENTER	263
MILD	218	SHELTERED WORKSHOP	75
MODERATE	144	OTHER DAY PROGRAM	57
SEVERE	138		
PROFOUND	94	ADAPTIVE BEHAVIOR	
		SAYS 10 WORDS	522
SEIZURE ACTIVITY		INDEPENDENT TOILETING	538
NONE/CONTROLLED	578	USES 3-4 WORD SENTENCES	490
LESS THAN MONTHLY	29	DRESSES INDEPENDENTLY	452
MONTHLY	11	CROSSES STREETS ALONE	308
WEEKLY	19	WRITES NOTES OR LETTERS	132
REQUIRED NURSING CARE		AVERAGE AGE (IN MONTHS)	374
LESS THAN MONTHLY	564		
MONTHLY	60	AVERAGE ADAPTIVE AGE (IN MONTHS)	65
WEEKLY	7		
DAILY	0	AVERAGE MALADAPTIVE SCORE	-9
CONSTANT	4		
		AVERAGE SERVICE SCORE	61
RECEIVES MEDICATION			
YES	307		
NO	341		

2. Description of Individuals Receiving and Awaiting Community Services by Planning Group

The ICAP data presented above regarding those receiving community services was used to assign the 648 community clients to an HSRI planning group. Additionally, data provided by the Division of MH/MR/SA, based on persons waiting for community services were also assigned to planning groups. Though this information did not involve ICAP assessments, it did provide sufficient profiles of those on waiting lists to assign each to a planning group. Figure 15 shows the distribution of those receiving and community services by planning group.

FIGURE 15: COMMUNITY CLIENTS AND PERSONS ON WAITING LIST BY PLANNING GROUP

CENSUS: AGE BY LEVEL OF FUNCTIONING
COMMUNITY PROGRAMS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	2,856	77	58	802	17	282	570	6	122	578	345
0-5	471	34	8	378	0	0	50	0	0	0	0
6-21	295	17	11	78	6	33	50	6	6	39	50
22+	2,090	27	39	345	12	248	469	0	116	539	295

PERSONS AWAITING SERVICE
AGE BY LEVEL OF FUNCTIONING
RESIDENTIAL PROGRAMS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	324	24	10	35	20	41	22	15	77	74	6
0-5	7	1	0	0	2	1	0	0	2	1	0
6-21	66	6	4	2	9	11	2	7	12	12	1
22+	251	17	6	33	9	29	20	8	63	61	5

PERSONS AWAITING SERVICE
AGE BY LEVEL OF FUNCTIONING
DAY PROGRAMS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	273	15	4	11	9	86	52	8	48	40	0
0-5	53	8	0	2	1	16	7	0	10	9	0
6-21	39	4	4	0	1	17	5	2	3	3	0
22+	181	3	0	9	7	53	40	6	35	28	0

Figures 16 and 17 display similar information on those awaiting residential and day services by age group and service area with Figure 18 displays persons in service by service area.

- the vast majority of persons awaiting residential and day services in the seven MR service areas are adults. These individuals are spread across all skill levels (I - IV).

- A sizable number of individuals are reported to have severe behavior problems.

- Nearly all persons awaiting service are ambulatory and only a few require on-site medical support.

FIGURE 16: PERSONS AWAITING COMMUNITY RESIDENTIAL SERVICES BY SERVICE AREA, PLANNING GROUP AND AGE

SEVEN SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	324	24	10	35	20	41	22	15	77	74	6
0-5	7	1	0	0	2	1	0	0	2	1	0
6-21	66	6	4	2	9	11	2	7	12	12	1
22+	251	27	6	33	9	29	20	8	63	61	5

THOMAS, LOWNDES & DOUGHERTY SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	116	8	6	13	12	15	8	11	13	30	0
0-5	1	1	0	0	0	0	0	0	0	0	0
6-21	35	3	3	2	6	4	1	4	4	8	0
22+	80	4	3	11	6	11	7	7	9	22	0

FULTON, COBB-DOUGLAS, DEKALB & GWINNETTE SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	208	16	4	22	8	26	14	4	64	44	6
0-5	6	0	0	0	2	1	0	0	2	1	0
6-21	31	3	1	0	3	7	1	3	8	4	1
22+	171	13	3	22	3	18	13	1	54	39	5

FIGURE 17: PERSONS AWAITING DAY SERVICES BY SERVICE AREA, PLANNING GROUPS AND AGE

SEVEN SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	273	15	4	11	9	86	52	8	48	40	0
0-5	53	8	0	2	1	7	7	0	10	9	0
6-21	39	4	4	0	1	5	5	2	3	3	0
22+	181	3	0	9	7	40	40	6	35	28	0

THOMAS, LOWNDES & DOUGHERTY SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	105	7	4	6	5	27	17	4	19	16	0
0-5	10	2	0	2	0	0	2	0	2	2	0
6-21	30	4	4	0	1	10	4	2	2	3	0
22+	65	1	0	4	4	17	11	2	15	11	0

FULTON, COBB-DOUGLAS, DEKALB & GWINNETTE SERVICE AREAS

	PLN GRPS	1	2	3	4	5	6	7	8	9	10
AGE:	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	168	8	0	5	4	59	35	4	29	24	0
0-5	43	6	0	0	1	16	5	0	8	7	0
6-21	9	0	0	0	0	7	1	0	1	0	0
22+	116	2	0	5	3	36	29	4	20	17	0

FIGURE 18: CURRENT COMMUNITY CLIENTS BY PLANNING GROUP, SERVICE AREA AND AGE

SEVEN SERVICE AREAS

AGE:	PLN GRPS	1	2	3	4	5	6	7	8	9	10
	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	2,856	77	58	802	17	282	570	6	122	578	345
0-5	471	34	8	378	0	0	50	0	0	0	0
6-21	295	17	11	78	6	33	50	6	6	39	50
22+	2,090	27	39	345	12	248	469	0	116	539	295

THOMAS, LOWNDES & DOUGHERTY SERVICE AREAS

AGE:	PLN GRPS	1	2	3	4	5	6	7	8	9	10
	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	1,275	17	21	270	12	160	300	5	36	253	201
0-5	139	5	0	108	0	0	26	0	0	0	0
6-21	176	0	9	37	5	23	32	5	5	23	37
22+	960	12	12	125	8	137	242	0	31	230	164

FULTON, COBB-DOUGLAS, DEKALB & GWINNETTE SERVICE AREAS

AGE:	PLN GRPS	1	2	3	4	5	6	7	8	9	10
	TOTAL ALL L-O-F	SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL III CHRONIC	SKL II OTHER	SKL I OTHER
ALL	1,581	74	38	542	4	120	255	0	85	324	139
0-5	332	34	11	275	0	0	11	0	0	0	0
6-21	119	24	0	48	0	8	16	0	0	16	8
22+	1,130	15	27	220	4	228	228	0	85	309	131

C. Comparison of All Study Populations by Planning Group

Figure 19 shows a comparison of all study populations for whom ICAP profiles were prepared, including those at GRC and Bainbridge, those awaiting placement at GRC, and a sample of persons receiving community services.

FIGURE 19: COMPARISON OF FOUR STUDY POPULATIONS USING ICAP PROFILES

ICAP INFORMATION	GRC (N=369)	BAINBRIDGE (N=196)	GRC WAIT LIST (N=70)	COMMUNITY (N=648)
SEX				
MALE	62%	67%	57%	54%
FEMALE	38%	33%	43%	47%
AGE				
0-17 YEARS	15%	10%	26%	11%
18-21 YEARS	13%	12%	26%	6%
22-39 YEARS	63%	55%	37%	60%
40-61 YEARS	9%	23%	10%	19%
62+ YEARS	0%	1%	1%	2%
MOBILITY				
WALKS	57%	100%	57%	87%
NON-AMBULATORY	43%	0%	39%	9%
LEVEL OF MR				
NO RETARDATION	1%	0%	0%	2%
MILD	1%	3%	7%	34%
MODERATE	8%	14%	9%	22%
SEVERE	20%	33%	17%	21%
PROFOUND	67%	48%	66%	15%
SEIZURE ACTIVITY				
NONE/CONTROLLED	62%	83%	77%	89%
LESS THAN MONTHLY	17%	10%	6%	4%
MONTHLY	8%	3%	1%	2%
WEEKLY	9%	3%	16%	3%
REQUIRE NURSE CARE				
LESS THAN MONTHLY	68%	54%	81%	87%
MONTHLY	6%	38%	10%	9%
WEEKLY	0%	2%	3%	1%
DAILY	1%	6%	1%	0%
CONSTANT	24%	2%	4%	1%
RECEIVES MEDICATION				
YES	89%	80%	64%	47%
NO	11%	19%	23%	53%

ICAP INFORMATION	GRC (N=369)	BAINBRIDGE (N=196)	GRC WAIT LIST (N=70)	COMMUNITY (N=648)
CURRENT RESIDENCE				
PARENTS/RELATIVES	0%	0%	67%	62%
FOSTER HOME	0%	0%	6%	7%
GROUP HOME	0%	0%	4%	16%
NURSING HOME	0%	0%	7%	0%
STATE INSTITUTION	100%	100%	7%	0%
OTHER RESIDENCE	0%	0%	9%	15%
FAMILY CONTACT IN MONTH				
YES	45%	23%	84%	87%
NO	55%	76%	16%	12%
CURRENT DAY PROGRAM				
NONE	8%	0%	26%	6%
SCHOOL	4%	6%	30%	4%
DAY ACTIVITY CENTER	14%	91%	30%	28%
WORK ACTIVITY CENTER	9%	0%	1%	41%
SHELTERED WORKSHOP	2%	0%	0%	12%
OTHER DAY PROGRAM	63%	1%	11%	9%
ADAPTIVE BEHAVIOR				
SAYS 10 WORDS	28%	37%	26%	81%
INDEPENDENT TOILETING	41%	65%	24%	83%
USES 3-4 WORD SENTENCES	24%	33%	23%	76%
DRESSES INDEPENDENTLY	19%	35%	16%	70%
CROSSES STREETS ALONE	7%	19%	9%	48%
WRITES NOTES OR LETTERS	2%	2%	3%	20%
AVERAGE AGE (IN MONTHS)	88%	196%	416%	58%
AVG ADAPTIVE AGE (IN MOS)	3%	11%	20%	10%
AVERAGE MALADAPTIVE SCORE	-3%	-12%	-24%	-1%
AVERAGE SERVICE SCORE	8%	15%	39%	9%

Figures 20, 21 and 22 display the number of persons assigned to each of the ten planning groups by three age groups and by study population. Figure 23 displays similar information for all age groups.

FIGURE 20: STUDY SUBPOPULATIONS: AGES 0-5 YEARS

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	PLANNING GROUPS 1 SEV IV OVRDG MED/PHYS	2 SEV IV OVRDG BEHVR	3 SEV IV CHRONIC & OTHER	4 SEV III OVRDG BEHVR	5 SEV III CHRONIC	6 SEV III OTHER	7 SEV II OVRDG BEHVR	8 SEV II CHRONIC	9 SEV II OTHER	10 SEV I OTHER
GRC RES & VTG/0-5	12	7	0	5	0	0	0	0	0	0	0
BSH RES/0-5	0	0	0	0	0	0	0	0	0	0	0
COMM IN-SVC/0-5	471	34	0	378	0	0	50	0	0	0	0
COMM VTG-RES/0-5	7	1	0	0	2	1	0	0	2	1	0
COMM VTG-DAY/0-5	53	8	0	2	1	16	7	0	10	9	0

FIGURE 21: STUDY SUBPOPULATIONS: AGES 6-21 YEARS

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	PLANNING GROUPS 1 SEV IV OVRDG MED/PHYS	2 SEV IV OVRDG BEHVR	3 SEV IV CHRONIC & OTHER	4 SEV III OVRDG BEHVR	5 SEV III CHRONIC	6 SEV III OTHER	7 SEV II OVRDG BEHVR	8 SEV II CHRONIC	9 SEV II OTHER	10 SEV I OTHER
GRC RES & VTG/0-5	127	34	2	77	1	10	1	1	0	1	0
BSH RES/0-5	43	1	3	28	0	4	5	0	2	0	0
COMM IN-SVC/0-5	295	17	11	78	6	33	50	6	6	39	50
COMM VTG-RES/0-5	66	6	4	2	9	11	2	7	12	12	1
COMM VTG-DAY/0-5	39	4	4	2	1	17	5	2	3	3	0

FIGURE 22: STUDY SUBPOPULATIONS: AGES 22+ YEARS

	PLANNING GROUPS										
		1	2	3	4	5	6	7	8	9	10
SUBPOPULATION/AGE:	TOTAL ALL L-O-F	SEL IV OVRDG MED/PHYS	SEL IV OVRDG BEHVR	SEL IV CHRONIC & OTHER	SEL III OVRDG BEHVR	SEL III CHRONIC	SEL III OTHER	SEL II OVRDG BEHVR	SEL II CHRONIC	SEL II OTHER	SEL I OTHER
GRC RES & VTG/22+	300	56	8	171	2	28	27	1	2	5	0
BSH RES/22+	153	3	14	105	1	17	6	1	2	4	0
COMM IN-SVC/22+	2,090	27	39	345	12	248	469	0	116	539	295
COMM VTG-RES/22+	251	17	6	33	9	29	20	8	63	61	5
COMM VTG-DAY/22+	181	3	0	9	7	53	40	6	35	28	0

FIGURE 23: STUDY SUBPOPULATIONS ALL AGES

	PLANNING GROUPS										
		1	2	3	4	5	6	7	8	9	10
SUBPOPULATION/AGE:	TOTAL ALL L-O-F	SEL IV OVRDG MED/PHYS	SEL IV OVRDG BEHVR	SEL IV CHRONIC & OTHER	SEL III OVRDG BEHVR	SEL III CHRONIC	SEL III OTHER	SEL II OVRDG BEHVR	SEL II CHRONIC	SEL II OTHER	SEL I OTHER
GRC RES & VTG/0-5	439	97	10	253	3	38	28	2	2	6	0
BSH RES/0-5	196	4	17	133	1	21	11	1	4	4	0
COMM IN-SVC/0-5	2,856	77	58	802	17	282	570	6	122	578	345
COMM VTG-RES/0-5	324	24	10	35	20	41	22	15	77	74	6
COMM VTG-DAY/0-5	273	15	4	11	9	86	52	8	48	40	0

IV. WHAT DOES THE CURRENT COMMUNITY SYSTEM LOOK LIKE?

A. Introduction to the Community System

The community mental retardation system in Georgia was one of the first to be initiated in the country. The system dates back to 1967 when the state legislature allocated money to support community-based day service centers for persons with mental retardation. The system, now is organized into 27 mental retardation service areas comprised of one or more counties. Each mental retardation program is part of a larger community mental health, mental retardation and substance abuse program which functions under the county health board. Responsibility for each of the 27 service entities lies with the county health officer.

In each mental health,mental retardation and substance abuse area in the state, the mental retardation portion of the program is managed by a developmental services chief. The developmental services chief reports to the director of the agency who in turn reports to the health officer and health board. The developmental services chief is assisted by mental retardation specialists who perform a variety of residential management, placement, monitoring, and administrative functions.

Unlike most other states, the community system in Georgia is primarily operated by public employees. With the exception of a few private, non-profit residential providers, the bulk of residential services are run by county employees. Day services are provided through 100 publicly operated Health Boards and through 30 local non-profit agencies. Though private day and residential providers are in most instances integrated into the local community system, they maintain a contractual relationship with the state not with the area mental health, mental retardation and substance abuse program.

The total community residential services budget is $17,555,074 of which $12,495,996 is state funds and $5,059,078 is supplied by federal SSI and SSDI funds. The current residential system serves approximately 1240 individuals. Day services are supported by $68,787,446 -- approximately 40% of which come from the federal Social Services Block Grant. At the end of 1986, day services were provided to 9,247 individuals.

B. Types of Day and Residential Services Offered

A great variety of day and residential services are offered in Georgia's communities to persons with mental retardation or other developmental disabilities. Those residential services that are offered include:

- ***Level IV community residences.*** Clients living in these residences have significant skill deficits and receive an intense degree training and supervision (and/or direct physical assistance) pertaining to nearly all skill domains. Additionally, they have secondary disabling conditions, such as serious medical problems, debilitating physical anomalies, or they display serious challenging behavior;

- ***Level III community residences.*** Persons living in these residences have significant deficits pertaining to basic care skills. They receive training, supervision and assistance that focuses on a variety of basic self help skills such as eating, toileting and dressing;

- ***Level II community residences.*** Persons living in these residences have mastered basic self help skills. They receive training, supervision and assistance that focuses on fundamental activities of daily living such as cooking, community mobility, household routines and shopping;

- ***Level I community residences.*** Persons living in these residences have mastered basic self help skills and many fundamental daily living skills. They receive training, supervision and assistance that focuses on more advanced skills of daily living such as budgeting, nutrition, paying bills and other topics relevant to independent living;

- ***Family personal care (Developmental training homes).*** These homes can house persons of any skill level. Typically, private community citizens offer to provide care within their own homes to one or more persons with disabilities; and

- ***Semi-independent living.*** Persons utilizing this service live in their own apartments or homes and have mastered many of the skills needed for independent living. These persons receive training, supervision or assistance as needed that focuses on advanced daily living skills.

Likewise, persons with mental retardation or other developmental disabilities may be receiving day services within any of the following types of programs:

- ***Preschool services.*** These services, targeted for children younger than five years old, are designed to maximize the child's attainment of age-appropriate developmental skills in a variety of areas including motor development, communication, socialization, self-help and cognition, and to diminish the need for specialized services later in life. This type of early intervention may be delivered in the child's home, in a setting outside the home, or in combination;

- ***Special education.*** These services, provided through the public schools for children of school-age, focus in the primary grades on teaching age-appropriate skills, emphasizing different types of skills depending on the nature and extent of the child's disability. As the child grows older, instruction focuses increasingly on developing community life and vocational skills. Services can be provided in any of four environments: the child's home, regular classrooms, special classrooms, and other specialized environments;

- ***Work activity centers.*** These centers are designed for persons deemed to have skill deficits so severe that their productive capacity is called into question. Persons assigned to WACs produce at a rate that is less than 50% of the production standard set for persons without disabilities by the Federal Wage and Hour Division of the US Department of Labor. While attending a WAC, clients may receive a range of habilitative and therapeutic services;

- ***Sheltered workshops.*** These programs utilize work experience and related services to promote progress toward a productive vocational status. Clients working in these shops typically are capable of producing at a rate of at least 50% of what is expected of persons without disabilities;

- ***Integrated vocational programs.*** This type of program places persons with disabilities into a job within the private community sector. Typically, clients are grouped together as an "enclave" or "industrial work station" and are supervised by program staff;

- ***Supported work programs.*** This type of program also places persons with disabilities into a job within the private community sector, but such placements typically accommodate a single client. The client is supervised by program staff or a "job coach." In many instances such support can be withdrawn as appropriate, with fellow workers eventually providing support as needed; and

- *Senior citizen programs.* These programs are designed for persons of advancing age for whom a vocational service objective is deemed inappropriate. The service focuses on teaching needed community living skills, but provides ample opportunity to participate in recreational and leisure activities.

Figure 24 shows the number of clients served within these day and residential service types by those agencies represented by persons responding to the Provider Survey (See Section I;E). The totals in service, therefore, are somewhat less than the total figures noted at the beginning of Section IV. The information shown suggests that, though a variety of services are available in the community, the most popularly used day service is the work activity center, while the most used residence type is the developmental training home. Whether the services these clients receive are most appropriate given their needs was not addressed by the survey, leaving this issue open to discussion.

FIGURE 24: NUMBER SERVED IN DAY AND RESIDENTIAL SERVICE BY RESPONDENT AGENCIES TO PROVIDER SURVEY

RESIDENTIAL SERVICE	NUMBER SERVED	DAY SERVICE	NUMBER SERVED
LEVEL IVA MEDICAL RESIDENCES	7	INTEGRATED PRESCHOOL	202
LEVEL IVB BEHAVIORAL RESIDENCES	44	SPECIAL EDUC. SERVICES	436
LEVEL III RESIDENCES	164	SEGREGATED PRESCHOOL	347
LEVEL II RESIDENCE	200	WORK ACTIVITY	4452
LEVEL I RESIDENCE	56	SHELTERED WORKSHOPS	291
FAMILY PERSONAL CARE (DTH)	419	INTEGRATED VOCATIONAL PROGRAMS	25
SEMI-INDEPENDENT LIVING	303	SUPPORTED EMPLOYMENT	309
		SENIOR CITIZEN DAY OPTIONS	32
		OTHER DAY SERVICE OPTIONS	892
TOTAL PERSONS SERVED	1193	TOTAL PERSONS SERVED	6986

While the above figures suggest that the bulk of individuals being served in the community are in developmental training homes and in work activity centers, the on-site interviews suggest a much richer service array. With respect to day services, the on-site interviews revealed that many local administrators are moving to diversify services and are initiating a range of innovative services including supported work, enclaves in industry, and community work crews. Further, with respect to residential services, project staff saw individuals living in a wide variety of arrangements including supervised and independent apartments, group homes, and other group care arrangements.

C. Specialized Support Services Offered

Aside from day and residential services, persons with disabilities may also require a range of specialized supports. Additionally, those providing care may also profit from services designed to enhance their caregiving capacity. Just as in other states, the availability of needed client and caregiver supports can vary by type of support and geographic area.

Figure 25 is based on results of the Provider Survey. The figure displays 22 service types and shows from what source survey respondents primarily obtain each service. Review of this figure suggests the following observations:

- Most types of medical services are available, though home health care, nursing care and dental care were deemed unavailable by some respondents;

- A significant number of respondents (N=23 of 43) indicated that dental services are obtained from the state institution;

- Other client supports, from case management to crisis intervention programs, are typically available, though each service was rated as unavailable by at least one respondent;

- Those client supports most often rated as unavailable include attendant care, occupational therapy, physical therapy and speech/hearing therapy;

- Most service agencies provide their own staff training;

- Though caretaker supports seem available in most areas, a significant number of areas are without needed technical assistance and do not offer families training or respite.

FIGURE 25: 22 SERVICE TYPES BY SOURCE OF SERVICE

SERVICE	SOURCE OF SERVICE							
	0	1	2	3	4	5	6	7
ROUTINE MEDICAL CARE		3	39		4			
EMERGENCY MEDICAL CARE		2	14		29		1	
HOME HEALTH CARE	6	2	8		2		26	
NURSING CARE	7	5	7		5	1	20	
ROUTINE DENTAL CARE	1	1	18	25	1			
ROUTINE EYE CARE		3	42	1				
CASE MANAGEMENT	4	40					2	
ATTENDANT CARE	13	11	10		1		10	
MENTAL HEALTH THERAPIES	3	12	4				26	
PHYSICAL THERAPY	9	11	11		5	2	7	
OCCUPATIONAL THERAPY	14	6	9		4	2	9	
SPEECH/HEARING THERAPY	9	10	14		4	2	6	
BEHAVIORAL CONSULTATION	3	30	5	1		4	2	
PSYCHOLOGISTS/PSYCHIATRISTS	1	16	15			2	12	
TRANSPORTATION SERVICES	6	40						
RECREATION PROGRAMS	3	34	2				6	1
CRISIS INTERVENTION PROGRAMS	3	38	1				4	
STAFF TRAINING		33	3				1	9
TECHNICAL ASSISTANCE	6	13	8	1.	1	3	7	6
FAMILY TRAINING/EDUCATION	9	32	1			3		1
EMERGENCY RESPITE	6	22		4	1		11	
NON EMERGENCY RESPITE	2	25	1	2			14	
TOTAL	103	389	212	34	57	19	164	17

KEY:

0. SERVICE IS UNAVAILABLE
1. AGENCY PROVIDES THE SERVICE
2. PRIVATE CONSULTANT OR PRACTIONER
3. STATE INSTITUTION
4. HOSPITAL-BASES SERVICE
5. CLINICAL EVALUATION TEAMS
6. ANOTHER SERVICE AGENCY
7. ALL OTHER SOURCES

In addition to the provider survey, project staff queried program providers and administrators from the seven target mental health, mental retardation and substance abuse service areas regarding the availability of specialized and support services. Their responses, which came during a group forum, support the findings above and suggest some additional issues. Specifically, with respect to individuals with serious behavioral and medical problems, the participants noted that additional consultation was needed in the area of neurology and pharmacology. Additionally, they noted the need for some form of back up residential crisis arrangement for individuals with challenging behavior. The group also noted that day service centers functioned in many instances without senior behavior specialists.

There was also a consensus regarding the need for additional supports for families with severely handicapped children. Problems in securing respite services were noted as well as an inability to provide supplemental services such as home adaptation.

During the course of site visits, problems in securing assistance for individuals with behavioral difficulties were noted. This was not universal, however. In Cobb/Douglas, for instance, program administrators stated that they had no trouble in securing psychiatric assistance for clients. They also noted, with respect to clients with medical difficulties, that responsive medical care was available on a routine basis.

With respect to the Clinical Evaluation Teams (where they exist), local administrators noted that CET personnel primarily perform diagnosis and evaluation at intake and are not, as a rule, available to supply back-up to providers of residential and day services.

D. Who Provides Care?

The community provider survey and on-site visits provide a picture of the direct care staff working in facilities serving persons with developmental disabilities throughout Georgia and in the target areas. This section will report on findings pertaining to: age and occupational achievement of community-based staff, turnover rates, salary, prior experience, amount of training received, and training needs. Where important, findings are contrasted by north and south target areas, public and private providers, and regions with high and low unemployment rates. Finally, a comparative assessment is made of community based and institutional staff.

- *Age:* 26% of all survey respondents (the largest percentage) indicated that the age group they most frequently draw from to staff residential facilities is persons aged 35-55. Twenty-one percent of the respondents indicated that persons aged 23-28 was the most predominant age group staffing their facilities. No respondents indicated that they use staff ages 17-22 as their first, second, or third most often used staff pool. These tendencies were consistent for both north and south target service areas.

Day facilities show greater use of younger staff, with respondents equally divided (34% and 33%) in terms of their use of staff ages 23-28 and 29-34.

- o *Education:* High school graduates was the most frequently used source of labor for 39% of residential respondents and 50% of day service providers. Thirteen percent of residential providers used staff with some college primarily, as did 17% of day providers. These tendencies were consistent for both north and south targeted areas.

- o *Recruitment:* Figure 26 shows that 66% (N=38) of survey respondents indicated that it takes four weeks or more to fill a day services direct care position, whereas 34% indicated that it took four weeks or less. In contrast, Figure 27 shows that 43% (N=30) of survey respondents fill residential service positions in four weeks or more, whereas 57% fill these positions in under four weeks. The most difficult position to fill is supervisory staff as revealed by Figure 28, with 75% (N=44) of respondents indicating that it takes over four weeks to fill a position and 25% showing less than four weeks. These findings did not significantly vary by regional unemployment rates.

FIGURE 26: TIME TAKEN TO RECRUIT DAY SERVICES STAFF

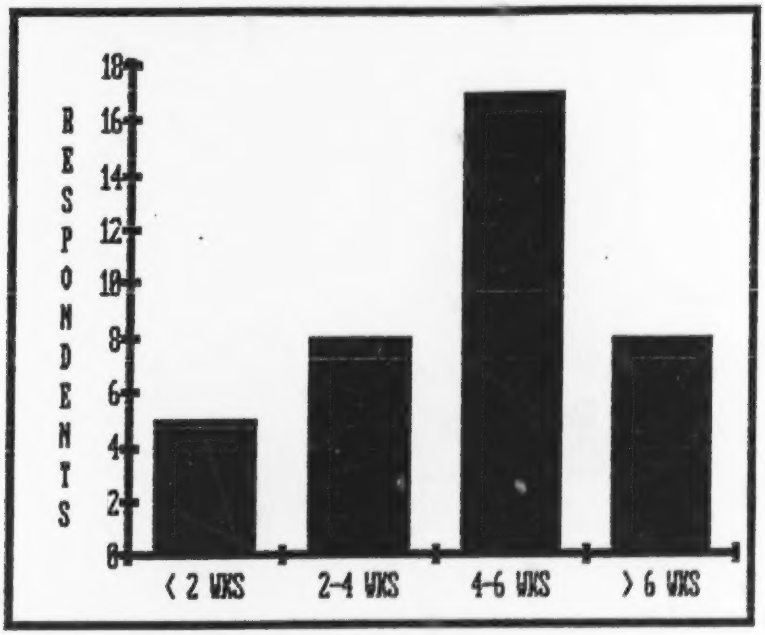


FIGURE 27: TIME TAKEN TO RECRUIT RESIDENTIAL SERVICES STAFF

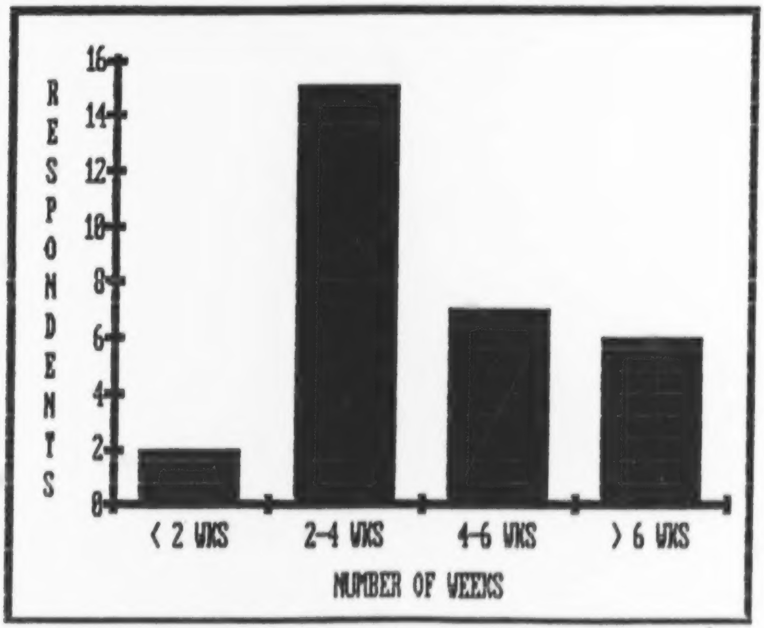
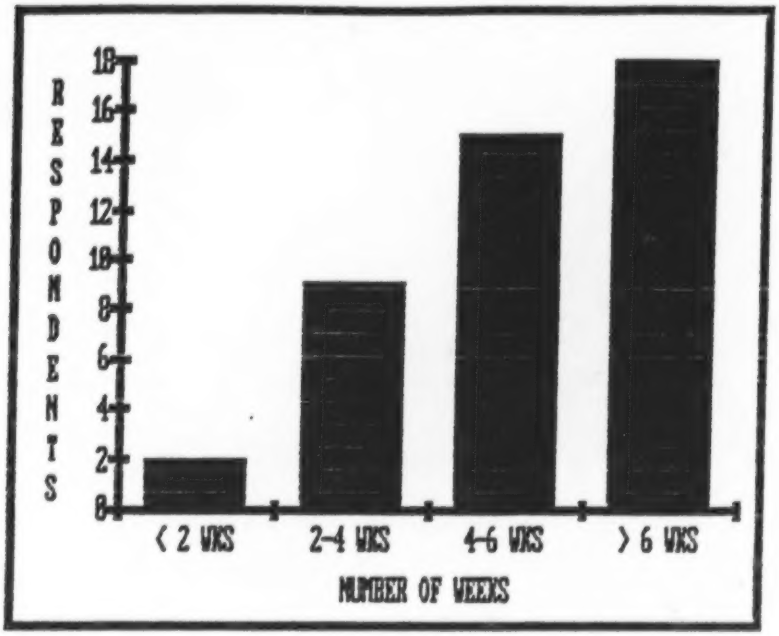


FIGURE 28: TIME TO RECRUIT SUPERVISORY STAFF



- *Turnover rates:* Based on the provider survey, the average annual turnover rate for full time direct care residential staff is 27%, and 26% for day facilities. In regions with a higher than state average unemployment rate (5.2%) the average annual turnover rates in day facilities decreases to 17%, whereas in regions with low unemployment rates (less than 5.2%) the turnover rates jumps to 31%. Turnover rates of residential staff in low and high unemployment areas did not show substantial change.

- *Staff salaries:* Mean salary rates for full time live-in residential direct care staff in public facilities is $12,267, whereas in private facilities it is $11,627. Mean salaries for public full time shift staff is $12,079. The mean for private residential fulltime shift staff is $12,000.

  Full time day service workers earn an average of $12,207 (range = $10,656 to $13,000).

- *Experience:* Figure 29 shows that 33% (N=30) of the respondents indicated that new residential direct care staff have no prior experience in providing community-based care, 53% have some prior experience. Only 14% of respondents indicated that staff were fairly or very experienced. (Other data are missing). Regarding day facilities, Figure 30 reveals that 47% (N=36) new day care staff have no experience, 45% have some experience, and only 8% indicating that new day staff are fairly experienced. These data were consistent for both north and south target service areas.

FIGURE 29: EXPERIENCE OF NEW RESIDENTIAL STAFF

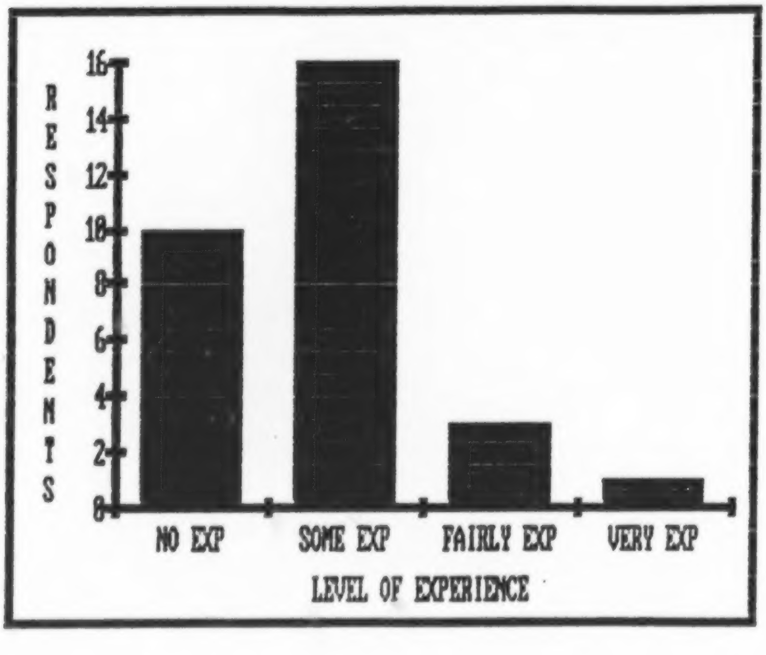
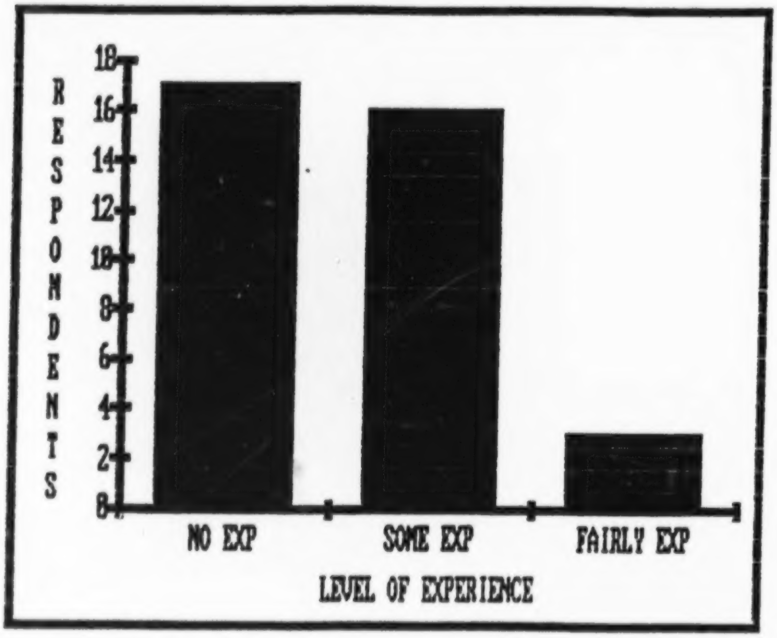
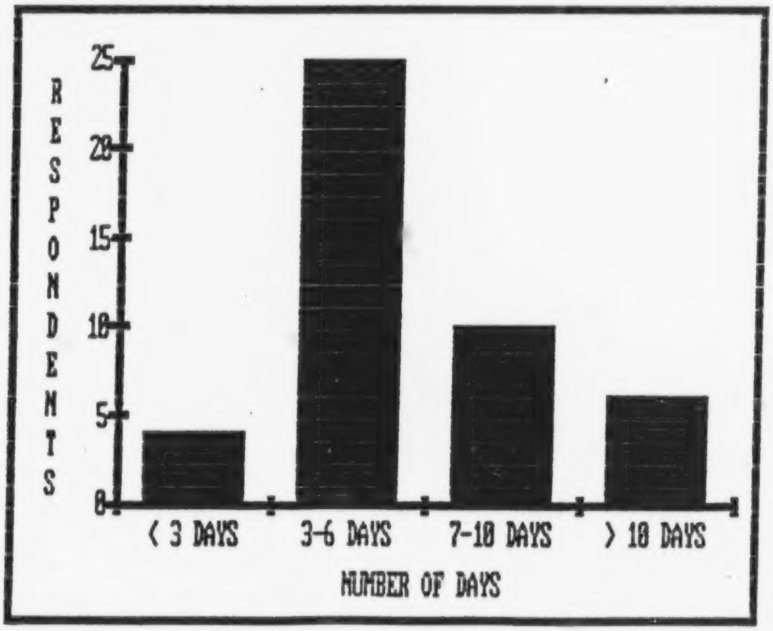


FIGURE 30: EXPERIENCE OF NEW DAY STAFF



- ***Amount of training:*** Figure 31 shows that 64% (N=45) of respondents indicated that direct care staff (both day and residential) received 6 days or less training in a given work year. Thirty-six percent indicated that staff receive 7 days or more training per year.

FIGURE 31: TRAINING DAYS OFFERED DIRECT CARE STAFF



- ***Training needs:*** Figure 32 reveals that the most frequently noted training need among all respondents was evenly divided between "teaching methods" and "crises intervention methods." Other frequently noted topics are: staff supervision, community integration/organization, facilitating client choice making, and sign language/communication. Four out of four southern targeted service areas differed from this pattern by noting their greatest training needs in the areas of physical and occupational therapy.

FIGURE 32: CITED TRAINING NEEDS

TOPIC	Number of Respondents Identifying Topic as a Training Need (Descending Order)	Number of Respondents Not Identifying Topic as a Training Need
Crisis Intervention	33	11
Teaching Methods	33	11
Staff Supervision	32	13
Community Integration	31	13
Client Choice Making	31	13
Sign Language	30	15
Verbal Counseling	27	18
Physical Therapy/OT	27	17
Choosing Ind. Objectives	26	18
Writing Program Plans	19	24
Normalization Principles	16	28
Household/Program Routines	14	30
First Aid	9	30

In sum, we find that community residential staff are predominantly middle aged with younger staff being used in day facilities. Most community staff are high school graduates, have had little or no prior experience in community-based care, and receive under 6 days of training per year. Average salaries for both day and residential facilities is $12,126 and the mean turnover rate is 26.5%.

Although the data presented above may discourage some with regard to the present capacity of community staff, it is important to review this data with several other points in mind. First, this overall picture of direct care staff is not substantially different in other states. Further, deinstitutionalization of persons, even with serious medical, physical and behavioral challenges, has occurred successfully given comparable staffing capacity in other states (Conroy & Bradley, 1985).

Another major consideration is the qualifications of direct care staff in Georgia's state institutions. The project team was not able to survey direct care staff employed at GRC or Bainbridge. However, anecdotal reports and on-site observations suggest that GRC is struggling with a high turnover rate among direct care staff, that institutional staff have educational achievements comparable to community staff, and have had little experience in the field at their time of hire.

E. Administrative Issues

In an effort to determine the level of administrative capacity at the local level, the provider survey included questions on three key areas: quality assurance, data availability and management, and case management.

1. Quality Assurance

Local providers and administrators were asked to describe the types of mechanisms employed to assess the quality of local services. Figure 33 displays the responses. As expected, virtually all of the respondents noted that they participated in the state's quality assurance reviews (inexplicably, two did not). The next most frequently used mechanism was some form of internal quality assurance. The preponderance of respondents also noted that they followed some form of grievance procedure. That seven respondents did not suggest they use a grievance mechanism may suggest a lack of information about the state's client grievance regulations.

FIGURE 33: QUALITY REVIEW PROCESSES EMPLOYED

REVIEW PROCESS	USED?	
	YES	NO
DIVISION QUALITY ASSURANCE SITE SURVEY	44	2
COMMISSION ON THE ACCREDITATION OF REHABILITATIVE SERVICES (CARF)	2	41
ACCREDITATION COUNCIL FOR SERVICES FOR MENTALLY RETARDED AND OTHER DEVELOPMENTALLY DISABLED PERSONS (ACMRDD)	1	42
PROGRAM ANALYSIS OF SERVICE SYSTEMS (PASS)	19	26
GRIEVANCE PROCEDURES FOR CLIENTS	38	7
INTERNAL REVIEW (SELF EVALUATION)	40	5
PEER REVIEW	27	18
CITIZEN OR PARENT REVIEW COMMITTEE	27	17

Interestingly, slightly less than half of the respondents noted that they used Program Analysis of Service Systems (PASS) as a form of program review. In contrast, very few respondents had successfully sought national accreditation. Finally, more than half of the respondents also employed some form of peer review and/or citizen and family review.

2. Data Collection and Program Management

An important aspect of community capacity is the ability to manage current services and to plan strategically for future service provision. In order to better understand these issues, respondents to the mail survey were asked to report on the types of information that they were capable of generating. Figure 34 displays the results of that question.

FIGURE 34: TYPES OF INFORMATION AVAILABLE TO LOCAL PROGRAM MANAGERS

TYPES OF INFORMATION	COULD IT BE PRODUCED?	
	YES	NO
NUMBER OF CLIENTS IN SERVICE	44	2
CLIENT DISABILITY TYPE	41	5
CLIENT FUNCTIONING LEVEL	39	7
CLIENT AGE	42	4
CLIENTS BY SERVICE RECEIVED	41	5
CLIENTS WITH INDIV. TRAINING PLANS	42	4
NUMBER OF CLIENTS DISCHARGED	41	5
STAFF/CLIENT RATIOS BY SERVICE	34	12
PROVIDER PER DIEM/UNIT COSTS	24	22
STAFF SALARIES PAID	41	4
ANNUAL EXPENDITURES BY SERVICE	36	9
STAFF TRAINING PROVIDED	42	3

The responses suggest that the vast majority of agencies are capable of generating information about the characteristics of the clients being served in the system. However, one half of the respondents are capable of producing information on per diem or unit costs, one fourth do not have information on staff/client ratios, and about 20% are not able to describe annual expenditures by service category. The ability to produce such information will be important in an expanded and increasingly sophisticated system.

3. Case Coordination

Key informant interviews and on-site reviews revealed that case coordination is currently being carried out by mental retardation specialists for individuals in residential settings and by service center staff for those individuals enrolled in day services. The current structure can therefore be characterized as an internal case management program (i.e., case managers work for the same organization that provides services). Interviews also suggested that coordination between residential and day service case managers was sometimes problematic.

In order to improve case management services, the Division is currently in the process of initiating a new program for persons with mental retardation as well as mentally ill individuals and substance abusers. The new unit will report to the area director of mental health, mental retardation and substance abuse and the proposed case load will be approximately 40. Since the new program will be reimbursable under Title XIX, clients must also be Medicaid eligible.

To gain a clearer picture of how case management was perceived by local providers and administrators, the survey asked for a ranking of the types of improvements that could be made. Figure 35 shows the results of this inquiry.

FIGURE 35: SUGGESTIONS FOR IMPROVED CASE COORDINATION

APPROACH THAT COULD BE TAKEN	WOULD IT HELP?	
	YES	NO
INCREASE THE NUMBER OF CASE MANAGERS IN THE SYSTEM	36	9
REDUCE THE CASELOADS OF INDIVIDUAL CASE MANAGERS	35	10
PROVIDE SOME CASE MANAGERS WITH TRAINING RELEVANT TO DISABILITY	34	11
SPECIFY MORE CLEARLY THEIR RESPONSIBILITIES	27	18
MODIFY THE TYPE OR AMOUNT OF PAPERWORK THEY MUST COMPLETE	38	7

These responses suggest that the majority of those responding feel that the numbers of case managers should be increased, that case loads should be reduced, and that case manager training should be increased. There is also strong sentiment to reduce the paper work currently involved in case management and to provide more specific descriptions of case management responsibilities. The state's proposed Title XIX case management mechanism will address many of these issues.

F. Community Acceptance

The extent to which local community attitudes and legal structures are hospitable to the development of programs for persons with mental retardation is crucial to the expansion of services. For this reason, several questions were included in the mail survey on this topic. Figure 36 displays community reaction to day programs and Figure 37 displays the community reaction to residential programs.

FIGURE 36: COMMUNITY ACCEPTANCE

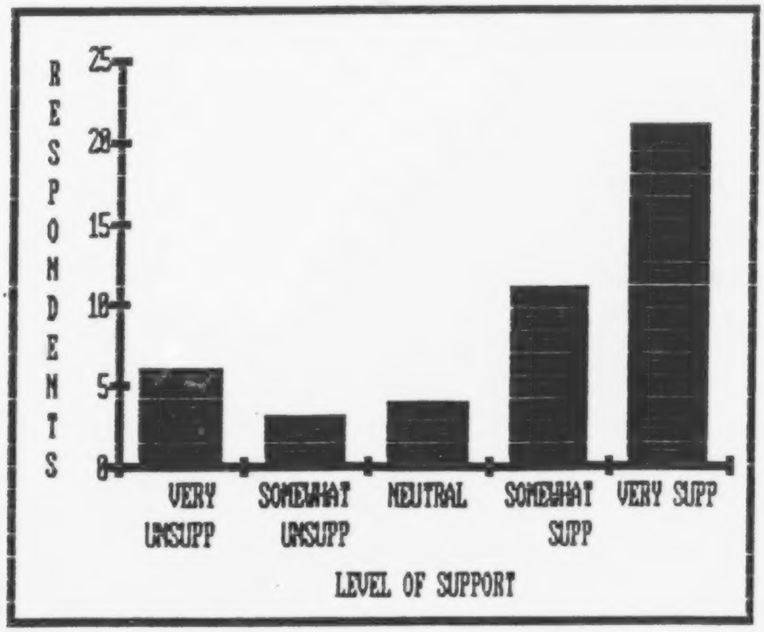
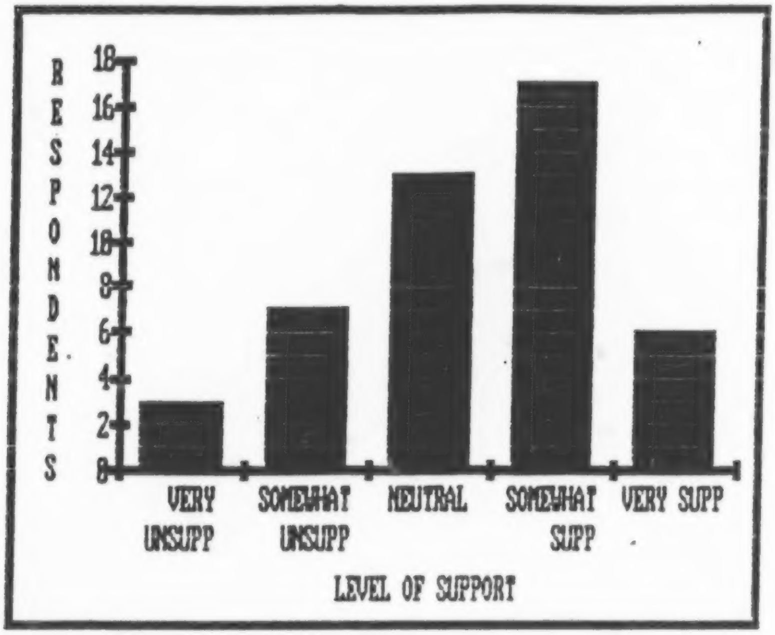


FIGURE 37: COMMUNITY REACTION TO THE ESTABLISHMENT OF RESIDENTIAL PROGRAMS

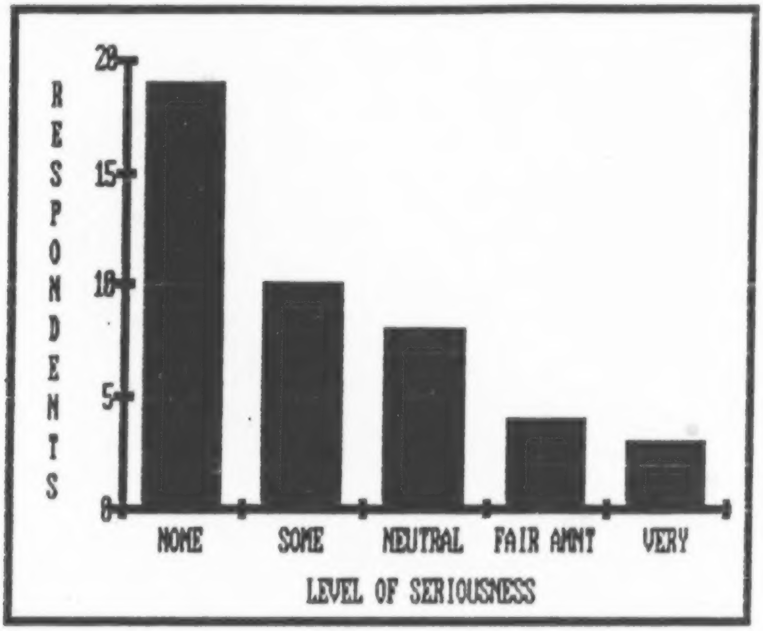


Not surprisingly, these responses suggest that community reaction to day programs is more positive than to residential programs. Given that day programs are more likely to be sited in commercial areas, one would expect more opposition to residential programs which are established in residential neighborhoods.

Site visits and key informant interviews also indicated that community opposition is hardly the norm. However, it appears that some local service areas have more serious problems than others. Specifically, interviewees in Fulton County noted extensive problems with community opposition. On the other hand, in Cobb/Douglas, little if any opposition had been experienced. Suffice it to say, that in those communities where opposition has cropped up, it has created lengthy delays in service initiation and the abandonment of some sites.

The survey also asked about the problems that local zoning ordinances posed in the development of community services. Figure 38 displays the responses.

FIGURE 38: IMPACT OF LOCAL ZONING REGULATIONS



The results of this question indicate that local zoning ordinances are not a serious constraint to the establishment of community services in most areas around the state. Those indicating problems included providers of public as well as private services. This suggests that even public facilities, even though technically not subject to local zoning, also encounter zoning obstacles. The site visit in Fulton county confirmed this problem. Seven respondents noted fairly serious or very serious problems. Private residential services are even more vulnerable to local zoning and key informant interviews confirmed that zoning obstacles have posed problems for such providers. If the state chooses to expedite the development of community services, then zoning constraints will have to be addressed at the state level.

G. Future Program Priorities

Though the Georgia system of community services offers a variety of services to persons with mental retardation and other developmental disabilities, many believe that much more must still be done to enhance the current service array. Divergent opinion exists, however, regarding what service objectives ought to receive the most attention.

Persons responding to the provider survey were asked to prioritize the top three system objectives in their area from a list of nine potential objectives. Figure 39 displays these objectives and the number of times each was assigned a first (highest priority), second or third rank. Review of this figure suggests that:

- Expanding community residential services ranks as the highest system priority, capturing 24 of the possible 46 first rankings. Additionally, the development of innovative residential models appears to rank second;
- While the development of family supports was ranked as one of the top three priorities by 27 of 46 respondents, it consistently was ranked third behind residential and day program priorities;
- Case management was ranked as the top priority by eight respondents, but was not ranked at all by the remaining 38; and
- Objectives related to day services were generally given high priority, with program expansion ranked first by five respondents and development of innovative options ranked second or third by 21 respondents.

FIGURE 39: PRIORITIES FOR SERVICE EXPANSION

POTENTIAL SYSTEM OBJECTIVE	RANKING			
	FIRST	SECOND	THIRD	NOT RANKED
IMPROVE CASE MANAGEMENT	8			38
IMPROVE STAFF TRAINING PRACTICES	1			45
EXPAND RESIDENTIAL SERVICES	23	4		19
EXPAND DAY PROGRAM SERVICES	5	12	1	28
DEVELOP INNOVATIVE RESIDENTIAL MODELS	8	10	3	25
DEVELOP INNOVATIVE DAY PROGRAM MODELS		13	9	24
DEVELOP FAMILY SUPPORT SERVICES	1	5	21	19
IMPROVE ACCESS TO HEALTH SERVICES		2		44
OBTAIN SPECIAL SERVICES			8	38
OTHER			4	42

V. WHAT DOES THE STATE SYSTEM LOOK LIKE?

A. Quality Assurance

This aspect of the management of state services to persons with mental retardation is particularly important to the considerations that govern the feasibility study. Specifically, the breadth and comprehensiveness of the quality assurance system will be particularly important for the following reasons:

- QA systems should dictate the programmatic parameters for the various service models that will be put into place for persons with more serious disabilities;
- QA systems should spell out staff qualifications and training requirements;
- QA systems should ensure the well-being of clients being served in the community;
- QA systems should ensure that prescribed services are in fact provided;
- QA systems should maximize the participation of peers, professionals, families, and consumers;
- QA systems should ensure that system values such as normalization and community integration are operationalized in system standards;
- QA systems should be clear and should communicate specific expectations;
- QA systems should provide access to grievance resolution mechanisms.

The following section is divided into five parts: licensing and facility oversight, program standards, monitoring, control and response, and client rights.

1. Licensing

There is one generic licensing category in the state that governs virtually all non-medical residential arrangements for more than one adult resides -- ***personal care home***. The regulations governing personal care licensure, therefore, also govern all current residential arrangements for persons with mental retardation. Given their scope, the substance of these regulations is crucial to the shape and content of any proposed residential facilities for persons targeted by the feasibility study.

Personal care licensing regulations are currently administered by the Office of Regulatory Services. Actual onsite reviews, however, are carried out by county sanitarians. Current regulations speak to three types of homes -- family personal care (2 to 6 adults), group personal care (7 to 15 adults), and congregate personal care (16 or more). Persons served in personal care homes, in addition to persons with mental retardation, include poor persons, persons with mental health problems, elderly individuals, and persons with physical disabilities.

Under the current regulations for personal care the managers of such facilities must meet very minimal training and educational requirements. There are no individualized program requirements based on category of individuals being served. Further, there is no upper age limit for the clients of such facilities nor is there an upper limit on the size of ***congregate*** personal care homes.

In addition to personal care home licensure, residential facilities must also meet state and local fire codes. The state fire code has been revised and has stiffened facility requirements. Some mental retardation mental health and substance abuse service areas have reported that the application of the new fire safety standards have placed some personal care homes in jeopardy. Local county and city jurisdictions can also adopt additional fire code provisions that go beyond those established by the state. DeKalb County was noted by many of those interviewed as having a particularly strenuous set of requirements.

2. Standards

Standards governing Georgia facilities serving persons with mental retardation are presently under revision. A new set of standards has been devised and is presently being tested. These standards incorporate standards that had been in use by the Georgia Division of Mental Health and Mental Retardation for biennial review of community mental retardation programs. The new standards are expanded and revised to include facilities also serving persons with mental health problems and substance abuse. Although the majority of the standards apply to all three types of facilities, others pertain to specific services. A table is presented in the front of the standards document detailing which standards are not applicable to all facilities. An "Inservice guide to key concepts and requirements" of the program standards is also available. This presents key aspects of the standards in a succinct and easy-to-read format. A survey instrument used by field staff to evaluate programs by the new standards illuminates the measures to assess programs.

The new standards are comprised of 22 chapters. Five of the chapters address specific types of day and residential services. The remaining chapters present generic standards covering, in part: client rights, staff development, case management, service records, safety and therapeutic environment, and community integrated services. The standards apply to all publicly operated facilities. Although most private provider contracts require adherence to the state standards, this may not be spelled out in all cases.

3. Program Monitoring

Another aspect of any quality assurance system is the capacity to monitor services to determine their compliance with standards and generally acceptable practices in the field. As noted in the section on community programs, some local mental retardation service areas have developed their own local monitoring including the use of families in DeKalb County. At the state level, monitoring currently takes place biennially. Under the proposed consolidated standards, monitoring will occur on an annual basis if additional resources are made available. The review will involve individuals in the quality assurance unit as well as in the mental retardation program unit.

4. Control and Response

The next component of a quality assurance system is a control and response mechanism. When problems are uncovered, the state must have the capacity to respond to rectify the situation either through sanctions or through support and technical assistance. This is particularly important when the interests of persons with more severe disabilities are at stake.

Several responses are currently available to the state. First, through the personal care home licensing regulations, a license can be withdrawn from non-compliant operators. The current regulations, however, are not particularly stringent and therefore do not offer a substantial basis for judgment. Further, the quality assurance process can result in the termination of a program if serious infractions are uncovered. One example of such a termination was described to project staff by a state interviewee. Unlike some states around the country, however, Georgia does not currently have a *receivership statute* that would make it possible for the state to take over non-compliant agencies in order to ensure continuity for the clients receiving services.

Another way of responding to problems of non-compliance is through technical assistance. While the Division currently provides ad hoc technical assistance through its program staff, there is no distinct unit vested with this responsibility.

5. Grievance Mechanisms

The final area of concern within a quality assurance system has to do with the exercise of client and family rights through a grievance mechanism. The State of Georgia does have an internal complaint and grievance mechanism which can be activated by the consumer or a family member or friend. Complaints can be filed regarding any service related concern. If the complaintant is not satisfied with the disposition of the quality assurance review committee at the mental retardation service area level, three additional levels of appeal are available culminating with a final appeal to the Director of the Division of Mental Health, Mental Retardation and Substance Abuse. There is, however, no external review provided.

B. Funding

Community-based habilitative services for persons with mental retardation and other developmental disabilities are funded with state general funds, federal Title XX (Social Service Block Grant) funds and third party payments primarily Supplemental Security Income (SSI), with some Social Security Disability Insurance (SSDI) and various other payments. Medicaid and Medicare funds are used to fund health care and therapeutic services for eligible clients.

State funds for residential services and for publicly operated day services (mental retardation service centers), and for respite care are allocated through a grant-in-aid process to the county board of health responsible for administering the mental retardation program in each of the 29 MH/MR/SA service areas. State funding for privately operated day services are issued directly through state contracts. Unless service providers exceed established staffing and operating cost guidelines, or fail to continue to serve the number of persons agreed upon, or there is an across-the-board cut in the state appropriation, providers continue to receive these base allocations at the same level as the previous year plus an allowance for inflation.

New funds for residential services are allocated on the basis of the four levels-of-care (I - IV) required for those clients identified to receive the services as explained in Section II; B; 1. Those clients requiring the highest level of care (level IV) receive the highest amount, and level I clients, the lowest amount. The average allocation per client is about $15,000 per year.

New funds for day services, about $3000 per client on average, are allocated to the service centers based on a formula that provides for staffing and operating cost limits with adjustments made for staff longevity, facility location, service area size, and so forth.

The state receives expenditure reports, and service providers are subject to audit to assure that residential and day service per diems do not exceed established ceilings set at the time of appropriation, and that line item expenditures (salaries, fringe benefits, etc.) do not exceed state guidelines.

All funds for respite care are allocated on a fee-for-service basis with the fees set by client level-of-care.

In June of 1987, in an attempt to capture federal funds to help underwrite community-based services in Georgia, the Division of MH/MR/SA together with the Department of Medical Assistance submitted a Title XIX, Home and Community-Based Services Waiver to the Health Care Finance Administration. The waiver covers 361 individuals who would otherwise require care in the state's large ICF-MR's, and 98 individuals currently residing in large ICF-MRs who would benefit from less restrictive community-based care.

If approved the waiver will allow the state to set aside provisions in the Medicaid legislation that essentially limit funding to medically-oriented long term care and health services for Medicaid eligible clients in favor of a less restrictive and less costly mix of homemaker services, home health services, personal care services, adult day health services, habilitation services and respite care. Funding for vocational and prevocational training services are specifically excluded.

The waiver would be granted for a period of three years and would then have to be renewed. The rate of federal financing participation in Fiscal Year 88/89 would be 63.04%.

C. Interagency Collaboration

To successfully bring about the phase down of two institutions in the state, it will be necessary for the Division of Mental Health and Mental Retardation to work collaboratively with a range of other agencies including the Division of Vocational Rehabilitation (DHR), the Department of Medical Assistance, Office of Regulatory Services, State Health Planning Agency, and the Department of Education. In order to understand the nature of these relationships, key informant interviews were conducted with each of these agencies. The specific areas of concern are as follows:

- *Department of Education* -- Preparation of alternative special education resources in the community;
- *Department of Medical Assistance* -- Title XIX support for alternative community resources;
- *Division of Vocational Rehabilitation* -- Extension of community day services;
- *State Health Planning and Development Agency* -- Future facility development plans;
- *Office of Regulatory Services* -- Licensing of expanded residential services.

These points are included to reinforce the importance of interagency collaboration. More detailed recommendations regarding interagency collaboration will appear in Part Two of this report.

VI. WHAT ARE THE ISSUES TO CONSIDER IN EXPANDING COMMUNITY SERVICES?

A. Allocation of Funds

The Division of Mental Health, Mental Retardation and Substance Abuse has only recently moved to the allocation of new residential service funds on a level-of-care basis. As this system develops and matures and hopefully comes to encompass day program and other habilitative services as well, it promises to provide a non-burdensome client-oriented funding mechanism allowing the flexibility needed to provide the most appropriate and cost effective complement of residential and related support services. To make this system viable, the following elements have yet to be thoroughly developed and tested:

- The establishment of a practical, valid and verifiable procedure for evaluating client level-of-care requirements;

- The development of a carefully conceived model of habilitative services by level-of-care comparable to that recommended in Part Two, but more refined and tailored to fit the Division's policies, objectives and context. The model needs to provide for sufficient resources to provide appropriate and adequate levels of client care; the level of funding currently available for client day services is, by the model recommended for the target populations, inadequate for clients at any level of functioning. The $15,000 allocated annually for residential services, while sufficient for many clients at levels I and II, would fall far short of the level required for clients at levels III and IV, the levels of functioning in which most of the residents who would be outplaced from GRC and Bainbridge are found;

- Quality assurance/case coordination procedures designed to assure the quality of the services provided these individuals;

- The relaxation of reimbursement structures and expenditure guidelines that make it difficult to use resources -- both day and residential -- in a flexible fashion based on individual need.

- The development of budget and expenditure reporting and auditing procedures based on a per capita mechanism for fund allocation.

B. Service Availability

Aside from their disabling condition, persons with mental retardation or other developmental disabilities have the same essential needs as anyone else. To the extent that their disability limits their capacity or carry out activities of daily living, however, they require supervision and/or support. Further, they must be afforded the opportunity to learn those skills necessary to increase their independence.

Stated in terms of particular service requirements, this translates into five general classifications of service: 1) residential, 2) day, 3) medical/health, 4) specialized support, and 5) caretaker support (designed for those providing care).

To assure their well-being and habilitative growth once outplaced, steps must be taken to provide -- within their new community settings -- the range of supports GRC and Bainbridge residents now receive. Moreover, in the interest of the client and the human service system in general, such supports should be designed to make greatest use of existing indigenous resources and to promote the full integration of these persons into their new communities.

1. Residential Services

As suggested by findings generated by the provider survey, the present community service system offers relatively few residential programs designed to accommodate those with the severest disabilities. Instead, reflecting the capabilities of those served, the residential models offered tend to provide less supervision and support than would be expected if the residents had fewer skills.

As shown in the previous section (See Section IV; B and C), the most popular residence types are developmental training homes (N=337), Level II community residences (N=192), and semi-independent living arrangements (N=274). In comparison, Level III residences, for those with few self-help skills, house 148 persons, while only 51 persons are served in Level IV residences designed for persons having extraordinarily severe disabilities.

These findings are cause for concern because persons at GRC and Bainbridge generally are less skilled than those presently served in the community. Moreover, there is a significant group of persons at GRC with serious medical complications that must be taken into account. These considerations suggest that to serve these persons well in the community, simply providing more of what is already available is not acceptable. Instead, residential options offering greater amounts of supervision and support than is now typically available must be implemented, including residences capable of providing needed medical care.

2. Day Services

The survey of GRC and Bainbridge residents (See Section II;B) shows that 146 persons, 103 at GRC and 43 at Bainbridge, are aged 21 years or younger. Once outplaced, these persons will require appropriate special education services. Though preschool and special education services are available, administrators of such programs will need to plan for accommodating these new students.

Regarding day services for adults, the primary service options presently employed are facility based, with the Work Activity Center serving the most clients. Given the skill levels of GRC and Bainbridge residents, providing day services within existing options seems appropriate, though the following factors must be considered:

- Some GRC and Bainbridge residents may have disabilities severe enough to preclude frequent participation in a center-based model that focuses on vocational objectives, suggesting a need for day options that accommodate persons with specialized needs. These options should involve a setting separate from the residence.

- Given the demonstrated skill levels of those community clients surveyed using the ICAP (See Section II;B), the heavy utilization of the work activity center may be inappropriate. Many persons presently served in this option may benefit from a less restrictive vocational model. With such movement, present slots within WACs could be used by GRC and Bainbridge residents, while alternate day options, more appropriately matched to the needs of current community clients, could be developed.

- Throughout the country there is an emerging move to implement vocational models that maximize the client's integration into his/her local community (e.g., supported work), even for those with severe disabilities. Some of these programs already exist in Georgia, though they are not as numerous as hoped by many. Thus, any decision to expand the current day service array must take into account this issue. Rather than developing or maintaining facility based programs, alternate models that stress community integration may instead be favored.

3. Medical/Health Services

Essential to any effort to provide community based services is the availability and accessibility of needed medical or health services. This is especially true for those residents who have serious medical complications or physical disabilities, a significant number of whom reside at GRC.

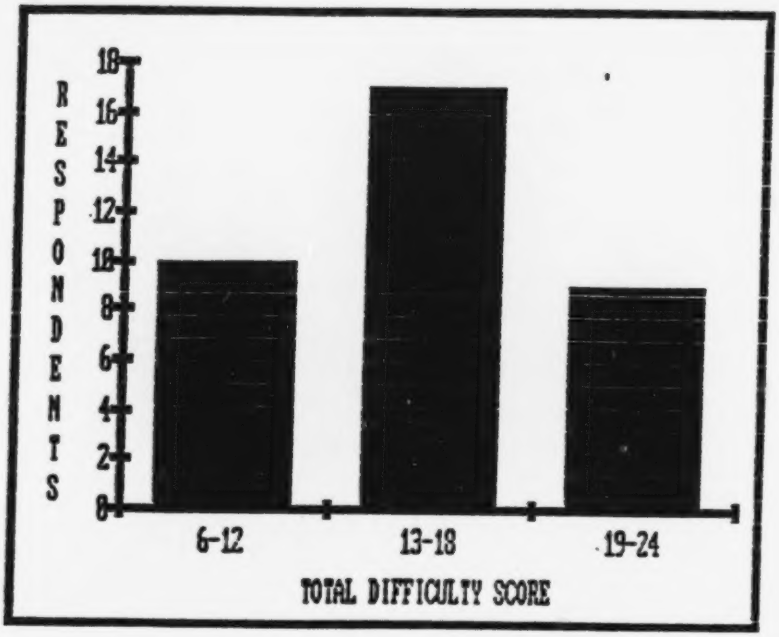
As shown earlier (See Section IV;C), respondents to the Provider Survey indicate that nearly all essential medical services are available in the community, though five respondents revealed that home health care and nursing care were unavailable and one revealed that dental care was not available. Overall, medical services were obtained either through private practitioners or at a hospital.

One notable exception pertains to dental care. Many survey respondents (N=25 of 46) indicated that the state institution is the primary source used to obtain this service. Recent changes in state regulations that allow community-based dentists to bill Medicaid for services rendered may alter these circumstances.

Aside from availability, survey respondents were also asked to rate on a scale of zero to four how difficult it is to acquire or obtain six health/medical services, including: routine medical care, home health care, emergency medical care, nursing care, dental care and eye care. The lower the rating given, the more difficult the service is to obtain. Ratings provided for all six services subsequently were summed to yield a "total difficulty score" pertaining to medical services. The highest score that could be attained is 24, indicating no difficulty with obtaining any service. The lowest score possible is zero, indicating a great amount of difficulty acquiring the six services.

Figure 40 displays results of these calculations for the 46 survey respondents (36 valid responses). As shown, ten respondents have little/no difficulty with obtaining needed medical services, 17 have moderate difficulty and nine have great difficulty. These findings suggest that though services are typically available, they are not always easily obtained. The design of programs for GRC and Bainbridge residents must surely take this into account. All clients require placement in settings where needed medical services are both available and accessible, an objective that is especially crucial for those with extraordinary medical needs.

FIGURE 40: OVERALL DIFFICULTY WITH OBTAINING SIX MEDICAL SERVICES



4. Specialized Support Services

Persons with disabilities living in the community may also require a range of specialized supports. Eleven such supports include:

1. Case management
2. Attendant care
3. Mental health therapies
4. Physical therapy
5. Occupational therapy
6. Speech/Hearing therapy
7. Behavior Consultation
8. Psychologists/Psychiatrists
9. Transportation services
10. Recreation programs
11. Crisis intervention programs

Referring again to Figure 25 (See Section IV;C), respondents to the provider survey indicate that these services are typically available in the community. Every service listed, however, was deemed unavailable by at least one respondent, with attendant care (personal care attendants for individuals with physical disabilities), occupational therapy, physical therapy and speech/hearing therapy topping the list of those support services in shortest supply.

These conditions should not be considered unique to Georgia. Attendant care services are not typically available in many states. Moreover, there appears to be a chronic shortage of therapy professionals that is felt coast to coast. The absence of these services in some areas, however, must be taken into account when considering the placement of GRC and Bainbridge residents, because many could benefit from these services.

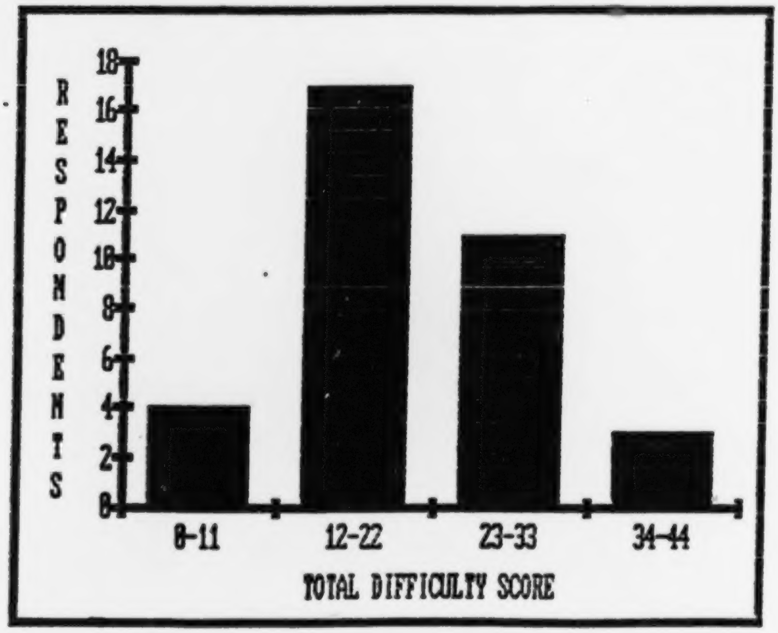
Aside from availability of services, survey respondents were also asked to rate the difficulty they experience in securing services on a scale of zero to four. The same scoring system noted above was used to yield a "total difficulty score" pertaining to the 11 support services. The highest score that could be attained is 44, indicating no difficulty with obtaining any service. The lowest score possible is zero, indicating a great amount of difficulty acquiring the 11 services.

Figure 41 displays results of these calculations for the 46 survey respondents (35 valid responses). When viewed this way, it is apparent that the majority of those responding have at least a moderate amount of difficulty acquiring the 11 support services. Very few (N=4) have little or no trouble acquiring the full range of support services.

These findings suggest that needed supports are not always easily accessed in many areas in Georgia. Thus, placement of GRC and

Bainbridge residents into the community must be carefully planned so that they reside in areas where they can obtain the services they need.

FIGURE 41: OVERALL DIFFICULTY WITH OBTAINING 11 SUPPORT SERVICES



5. Caretaker Supports

Key to the success of any human service system is the competence of its direct and supervisory staff. Such staff must receive the training they need to acquire an understanding of the underlying purposes and philosophy of the program, as well as knowledge regarding best habilitative practice. Moreover, given unique challenges or program goals, staff must also have access to needed technical assistance. Likewise, family members who provide care at home may need services designed to enhance their capacity to provide care.

Given this concern, respondents to the community provider survey were asked to rate the difficulty they experience in acquiring these five caregiver supports:

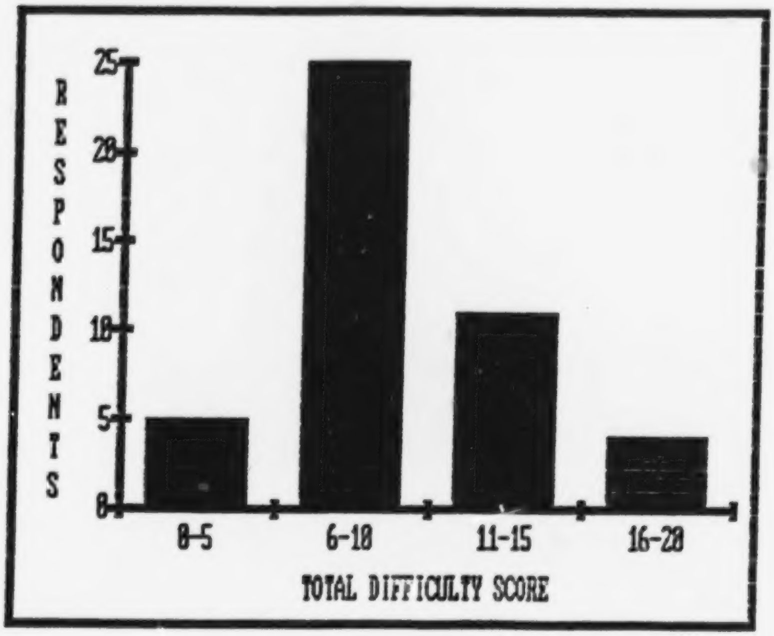
1. Staff training
2. Technical assistance
3. Family training/education
4. Emergency respite
5. Non-emergency respite

Again, respondents rated the difficulty of each from zero to four and their ratings were summed to yield a "total difficulty" score pertaining to caregiver supports. The highest score possible was 20, indicating no or little difficulty, and the lowest possible score was zero.

Figure 42 displays the results of these calculations, given 45 valid responses. As shown, the great majority (N=30 of 45) indicate at least moderate difficulty acquiring caregiver supports; only four specify that they have little/no trouble. These findings prompt concern over the accessibility of caregiver supports.

Note that the GRC and Bainbridge clients appear, on average, to have greater skill deficits than do community clients. Additionally, some at GRC have serious medical complications or physical disabilities. The community staff who provide services to these persons will require competencies tailored to the needs of these clients. Present community staff may not yet possess these competencies, given that they serve relatively few clients of with such disabilities. Thus, in placing GRC and Bainbridge residents into communities, care must be taken to provide staff with the training they will need.

FIGURE 42: OVERALL DIFFICULTY WITH OBTAINING FIVE CARETAKER SUPPORTS



C. Labor Availability

Assessing the adequacy of the labor available in the community to support to phase-out GRC and Bainbridge began with a projection of the numbers and types of staff that would be required. Four types of staff, those most critical to successful community programs, were reviewed: a) direct care staff, b) supervisory staff, c) special habilitative staff (i.e, physical, occupational and speech therapists, psychologists, behavior specialists), and d) medical services staff.

Figure 43 shows the numbers of selected types of staff needed to meet the staffing requirements of the projected community-based programs, and the numbers in each staff category presently employed or allocated to GRC and Bainbridge. The methods used to determine the projections of needed direct care staff and habilitative staff are explained in Part Two, Section III, A(1). Projections of the supervisory personnel needed are based on direct-care to supervisory staff ratios for various program types provided in Touche, Ross and Company (1984). Present data constraints on community utilization of health services prevent making estimates of the numbers of nursing staff needed.

FIGURE: 43: STAFF PROJECTIONS

	Staff Requirements for Community Based Services		Number of Positions*	
	GRC	Bainbridge	GRC	Bainbridge
Direct Care	707	301	578	232
Supervisory staff	64	27	30	9
Physical Therapists	7	1	6	1
Occupational Therapists	4	1	6	2
Speech Therapists	8	3	6	2
Psychologists	5	2	6	2
Behavioral Specialists	15	4	15	4
Nurses	unknown	unknown	51	16

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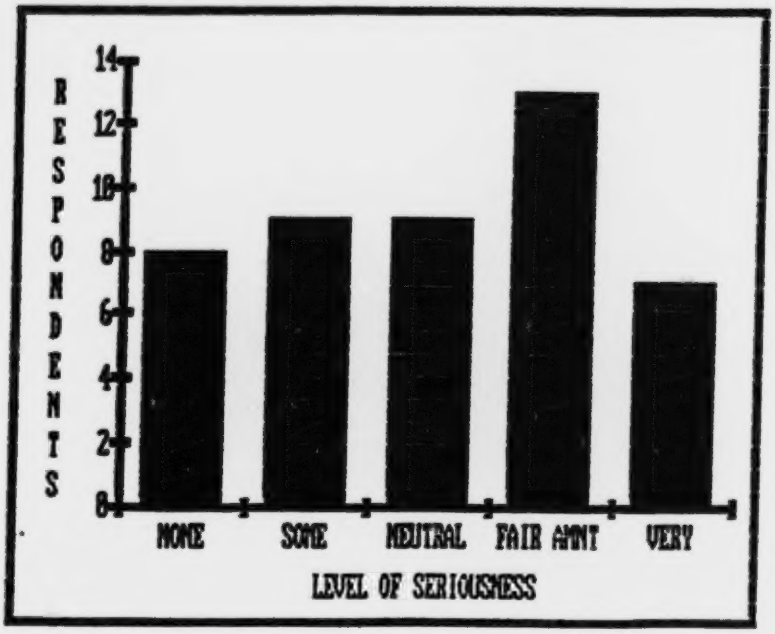
* Numbers of habilitative staff do not include senior administrators who are not likely to be providing direct services. Supervisory staff include team leaders and unit directors.

Given the staffing requirements shown by Figure 43, a manpower assessment was conducted for the seven targeted regions. Overall, as shown by Figure 44 the limited availability of labor was considered to be a potentially serious deterrent to program expansion by 42% of those responding to the community provider survey, while 37% did not consider it to be a serious problem. While examining the issue in greater depth two very different pictures emerged for the north and south targeted areas. The circumstances in each are discussed separately below.

FIGURE 44: LABOR RESOURCES



1. Southern Target Counties

a. Direct care staff

The projected number of direct care staff needed to serve Bainbridge residents in alternative community settings shows an increase of about 70 staff over the numbers presently employed. This may appear to indicate a rather rich staffing ratio for the community. However, due to the decentralized nature of community services and the multiple functions community direct care staff perform in comparison to institutional patterns where specialized staff are employed (e.g., housekeepers, cooks, maintenance staff) such ratios are needed.

We can safely assume, unless a high number of clients are relocated more than hours drive away from Bainbridge, that a significant number of the Bainbridge direct care staff would continue to provide community-based services. This assumption is based on the following:

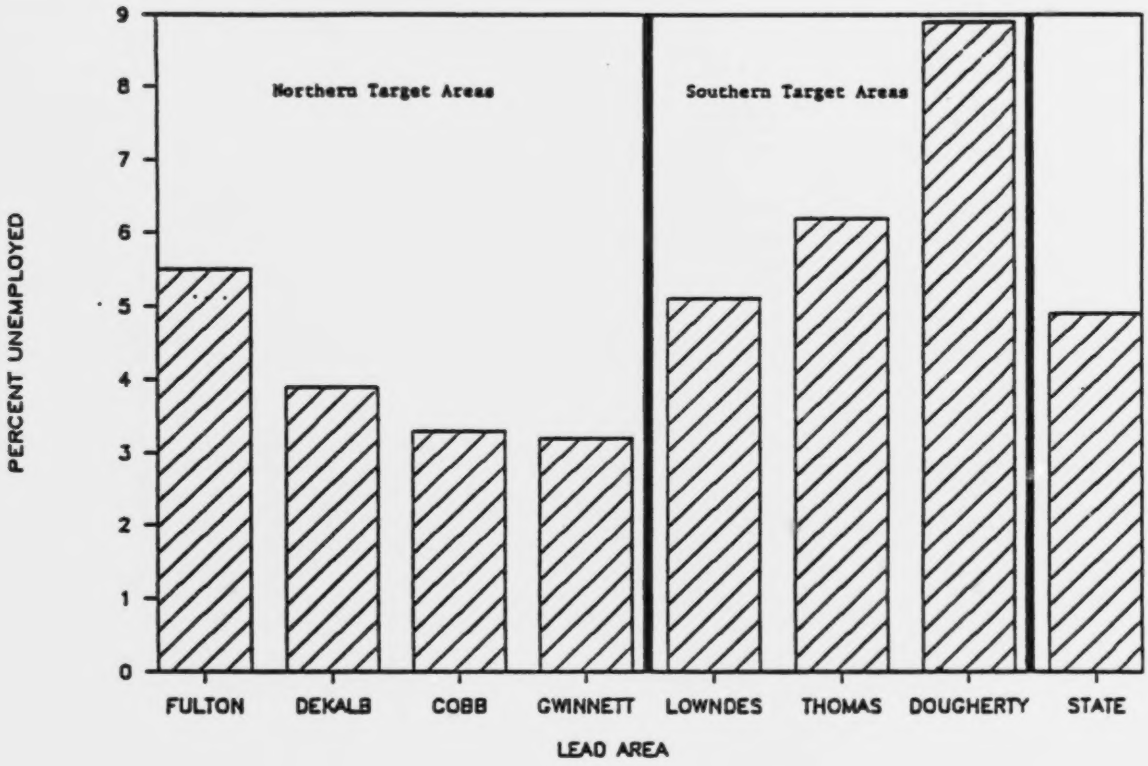
- Experience relocating institutional staff in other states (Heller, et al. 1986);

- Anecdotal reports from the state hospital staff regarding their willingness to take community-based jobs;

- The relatively high unemployment rates in the three targeted Southern service areas (See Figure 45 below for unemployment rates in the seven targeted regions); and

- The security and benefits provided to publicly employed personnel.

FIGURE 45: UNEMPLOYMENT RATES IN SEVEN TARGETED AREAS



The numbers of institutional staff moving to jobs in the community will depend in part on whether private service providers are able to offer wages comparable to those earned while at the institution, and the extent to which staff have to commute long distances to their new job. Nonetheless, in light of the relatively high unemployment rates in all three areas, there is a good chance that a substantial number of institutional staff will want to transfer to community programs.

b. Supervisory staff

As indicated in Figure 28, acquiring needed numbers of supervisory staff may pose a larger problem than will direct care staff. An increase of 18 supervisory staff over those currently employed at Bainbridge is projected. Strategies by which this problem can be addressed are discussed in Part Two.

c. Specialized habilitative staff

Indications are that securing a sufficient number of professional therapeutic staff in the Bainbridge area will be difficult. This assessment is based on the following:

- ***Key informant interviews:*** Reports from community service administrators and professional association members suggest that securing professional therapeutic services in southwest Georgia is very difficult. Professional therapists are not willing to work for the lower wages often offered by community-based providers, nor are they willing to relocate to rural areas of the state such as Southwest Georgia. Even the Valdosta Medical Center reports difficulty filling hospital positions for physical therapists.

- ***Labor statistics:*** Data from two of the three southern regional Departments of Labor show that no physical, occupational or speech therapists have sought work in the past year. (There are no unemployment rates by occupation available in Georgia).

- ***General labor shortage:*** There is a critical shortage of physical therapists throughout the United States.

- ***Insufficient professional education programs:*** There are only a handful of professional education programs in Georgia. Except for one speech therapy program at Valdosta State College, all are located in the northern half of the state, making future recruitment difficult.

- ***Recruitment difficulties at Bainbridge:*** Personnel reports from Bainbridge indicate that the present position for a physical therapist is unfilled and has been for some time. They are only able to contract with a physical therapist who commutes from Tallahassee for 8 hours a week. Of the two positions available for speech therapy, one is vacant. Both occupational therapist slots have been recently filled; this was only accomplished by reclassifying the positions to the upper end of the pay scale. Additionally, several behavior specialist positions are vacant.

- ***Community provider survey results:*** Finally, results of the provider survey support this conclusion:

  -- A scale measuring the difficulty in accessing services was correlated with regional unemployment rate. (All three southern regions have high unemployment rates, although Lowndes county is 0.1% under the state average rate of 5.2%.) For physical therapists an inverse correlation of .28 ($p<.06$) was found suggesting that as unemployment rates go up it grows increasingly harder to obtain physical therapists; and

  -- Using proximity to a major city as as an identifier of urban and rural regions, we find that the same scale measuring the level of difficulty in securing client support services (including physical, occupational, and speech therapies) shows that providers in rural areas have more difficulty in securing therapeutic support services than do providers in urban regions ($t=-1.41$, $df=19.48$ $p<.006$).

It is clear that accessing professional rehabilitative staff is already a problem in the Bainbridge area and appears to be difficult for many other community service providers as well. On-site interviews confirm that securing behavior specialists is a problem. The only specialized habilitative staff not likely to pose a recruitment problem are psychologists. Both psychologist positions in Bainbridge are presently filled. Further, Department of Labor data suggest that there are numerous psychologists unemployed (939 had applied to labor offices for work in the past 12 months across the state) and it seems plausible that a sufficient number of them can be induced to work for southern regional programs.

d. Medical services staff

As only four persons at Bainbridge show overriding medical needs, it appears that existing community health service system will suffice for the medical needs of Bainbridge clients. Community hospitals, pharmacists, physicians, and home health organizations can address the needs of most Bainbridge consumers. Some Bainbridge nursing staff can be trained to provide the community-based health monitoring services that other consumers will require.

2. Northern Target Communities

a. Direct care staff

In contrast to the southern target service areas, the chief labor constraint to placing GRC residents into the community concerns the acquisition of direct care staff. There are several findings that support this conclusion:

- ***Unemployment and staff turnover rates:*** As shown by Figure 45, three out of the four target service areas show very low unemployment rates with the exception of Fulton County which has an unemployment rate of 5.5% (.3% above the state average). Additionally, using data generated through the community provider survey, a t-test on reported turnover rates for community day services staff and regional unemployment rates show a suggestive though not conclusive relationship between low unemployment rates and higher rates of turnover ($t= 1.86$, $df=23$, $p<.07$). Studies in other parts of the country confirm that low unemployment rates are correlated with high direct care staff turnover and difficulties in recruiting staff (Lakin & Bruininks, 1981; HSRI, 1987).

- ***Key informant interviews:*** Several anecdotal reports suggest that GRC already experiences troubling turnover rates among direct care staff and that some community providers have difficulty filling direct care positions. Given the strong employment picture in the Atlanta metro area, key informants suggest that direct care staff will leave positions for work elsewhere that pays as little as 10 cents more per hour. Although interviews suggest that GRC staff will accept jobs in the community, a plausible scenario is that some staff will find higher wages and more attractive schedules elsewhere.

- ***Labor statistics:*** Data collected from four local labor offices in the metro Atlanta area covering all four target service areas shows that a total of only 23 persons applied for work comparable to community direct care position in the past 12 months.

- ***Community provider survey results:*** Several findings from the provider survey are worth noting:

  -- As indicated in the general description of direct care staff, we find that turnover among day service direct care staff jumps from 17% in areas with high unemployment rates to 31% in regions with low unemployment rates.

  -- In a question regarding troublesome aspects of recruiting direct care, a statistically suggestive difference was found between those regions with high and low unemployment rates regarding "insufficient number of applicants" (chi-square= 3.4, df=1, p<.07). This suggests that the northern target service areas have greater difficulty, than those in areas with higher unemployment, with attracting sufficient applicants for direct care staff positions, and may have to "settle" for less qualified applicants.

  -- In the same question on recruiting direct care staff, regions with low unemployment rates show a statistically significant difference regarding their ability to offer sufficient compensation to attract direct care staff from regions with high unemployment rates (Chi-square=4.3, df=1, p<.04). This suggests that low wages has a substantial impact on the ability to recruit direct care staff in the northern target service areas where labor market conditions are quite competitive.

Although recruiting sufficient direct care staff appears to be a potential constraint on the expansion of community services for GRC consumers, the picture is more optimistic for medical and professional rehabilitative staff.

b. Supervisory staff

As discussed in the previous section, on the whole the recruitment of supervisory staff poses a greater problem than does the recruitment of direct care staff. An additional 34 supervisors are projected for the community programs, than are presently employed at GRC. Given the apparent constraints facing recruitment of direct care staff in Northern counties we can well assume comparable or greater difficulties in recruiting supervisory staff.

c. Specialized habilitative staff

Although securing habilitative personnel presents some complications for northern target service areas, there are several indicators that suggest that adequate personnel for GRC consumers can be obtained.

- At present all habilitative positions at GRC are filled. If all of these staff accepted community jobs they could, with careful placement of consumers, provide for nearly all of the projected needs of GRC residents, except for two speech therapists and one physical therapist.
- Labor statistics do not indicate that many habilitative personnel are seeking work. However, unlike the Southern counties, they do show some unemployment in these occupations. In the past year, eight occupational therapists sought work from the Georgia Department of Labor in the Atlanta metro areas, and as did six physical therapists, and 145 psychologists.
- Nearly 100% of the training schools in professional therapies are in the Northern half of the state. Given the attractiveness of working in the metro Atlanta area, collaborative strategies with professional programs, and/or aggressive recruitment, will likely be successful in recruiting any of the additional therapeutic staff that may be required.

d. Medical Services

Given the critical medical needs of many consumers at GRC sufficient availability of medical services becomes a crucial concern. As indicated in the preceding section, most medical services are available in most parts of the state. However, the data does not indicate whether these medical personnel have sufficient expertise to accommodate the complex needs some GRC consumers have. Further, one respondent from a northern service area indicated that home health care was unavailable, one indicated that nursing care was unavailable and one indicated that attendant care was unavailable. This would suggest that although medical services are generally available, *placement of consumers with complex needs should take into consideration proximity of skilled medical personnel.* Labor statistics also indicate that in the past year, 51 nurses and 186 licensed practical nurses applied seeking work in the metro Atlanta area. Given that this represents only 10-15% of persons seeking work it would appear that there is an ample pool of nurses to draw from, apart from those nurses and health professionals already employed at GRC.

D. Community Acceptance

In order to proceed with any substantial deinstitutionalization effort, it will be necessary to address issues of community acceptance. Such an effort will require a systematic set of activities coordinated at the state level and implemented locally. Such an effort will be particularly important assuming that additional private providers will be necessary to ensure an adequate number of community placements.

Traditionally, the resistance of communities to the development of group homes is based on the assumption that group homes and the residents of group homes will have a negative impact on the neighborhood. Neighbors fear that the presence of these homes in the community will cause the value of nearby properties to fall. Further, some neighbors are concerned that the stability of the neighborhood will decline because group homes house a transient population. Finally, others fear that bringing "unfamiliar" persons into the community will result in an increase in the crime rate because the residents will engage in criminal behaviors or will become the victims of crime.

Numerous studies have been undertaken in response to these concerns. For example, between 1983 and 1985, Daniel Lauber (1986) conducted a well-designed, comprehensive study in Illinois that examined the impact of 14 group homes on surrounding property values, residential stability, and neighborhood safety. Results of this longitudinal study confirmed that there were no significant differences between the study group neighborhoods and the comparison neighborhoods on the key study variables: property values, community stability, and neighborhood safety. A major thrust of this study was to expand the reliable data necessary to counter community opposition to group homes.

Public education has frequently been used to change community attitudes toward persons with mental retardation and to reduce community opposition to group home development in neighborhoods. Public relations campaigns are directed toward changing two types of beliefs about mental retardation. The first set of beliefs concerns the capabilities of persons with mental retardation; and the second concerns the consequences of group home development in neighborhoods (Cnaan, Adler & Ramot, 1987).

The public education strategy is based on the notion that providing more information and increasing public knowledge about an "unfamiliar" group will reduce fear and prejudice by changing preconceived ideas. Acceptance of persons with mental retardation and less resistance to the development of nearby group homes will result.

One example of a massive public relations effort began in Florida in 1985. As a result of the Florida Developmental Disabilities Planning Council's failure to get a zoning bill passed that would allow group homes in single family neighborhoods, the Council decided to engage in an extensive public relations campaign to change attitudes. The group homes targeted in the media campaign included housing for children, for elders, and for persons with developmental disabilities and emotional problems. This media campaign presented information about the need for group homes and the importance of changing existing zoning laws to open the way for group home development in single family neighborhoods (Florida Department of Health and Rehabilitative Services, 1987). Interestingly, the Florida media campaign was launched in response to adverse publicity resulting from discussions concerning the bill in the legislature.

Results from several states suggest that massive public relations campaigns prior to the opening of group homes in single family neighborhoods may result in increased opposition. As part of the deinstitutionalization of the Pennhurst State Center in Pennsylvania, researchers at Temple University conducted a longitudinal study that examined changes in the attitudes of neighbors toward having persons with mental retardation living in their neighborhoods. The results of this study suggested that community opposition was greater when the group homes were anticipated by neighbors than when they were actually experienced by neighbors (Conroy & Bradley, 1985). In addition, the researchers also found that neighbors became more favorable toward group homes over time.

These investigators recommend that developers of group homes avoid pre-opening publicity. Structured contacts in the neighborhood following the opening of the home could result in more favorable attitudes of neighbors toward the group homes. Further, these researchers also reported that:

> ...respondents who knew of the community living arrangement reported feeling more favorable toward the community living arrangement over time; but neighbors cannot grow to accept or welcome community living arrangements if they are prevented from opening (Conroy & Bradley, 1985, p. 215).

In another study investigating key factors associated with community support or opposition to group home development, a Massachusetts researcher concluded that opposition to group homes was less likely to occur when neighbors learned of the residences following the opening rather than during the six months preceding the opening (Seltzer, 1984).

Other results from this study suggest that greater support for community residences might be more likely in neighborhoods where there are fewer home owners relative to renters (Ibid, 1985).

E. Quality Assurance and Licensing

1. Standards

A critical component of any quality assurance mechanism is the written standards by which programs are evaluated. The Georgia standards presently being testing are both adequate and in some aspects comprehensive, reflecting "state-of-the-art" thinking about quality habilitative programming for persons with mental retardation. However, given the influx of hundreds of additional consumers to the community system there are certain aspects of the standards that require greater detail and some revision. The aspects discussed below are: personnel, functionally based training, "state-of-the-art" habilitative programming, and operationalized outcome measures.

a. Personnel

In general, the quality of services is only as good as the people who provide the services. As an independent document, the new standards present no minimum qualifications for staff. Presumably, these requirements are outlined in the state job classification system. However, given expanded private sector service provision the detailing of minimum qualifications becomes essential. Data from the provider survey indicates that even in areas facing low unemployment rates, no provider has to rely on persons without a high school education to staff their facilities. Similarly, no providers indicated that they are relying on persons under age 19 to staff facilities. It would appear that minimum qualification could be set in these areas without stressing labor availability. Qualifications in age or educational achievement could help assure that program plans are written, that records are adequately kept, and that ascertain degree of mature judgment is brought to bear in the supervision of daily consumer activities. ***Minimum qualifications for professional staff***, such as licensing and/or experience with developmental disabilities is also not mentioned in the standards. Again, this becomes an area to address in light of more private providers.

Another concern pertaining to personnel is ***staff to client ratios***. Although some minimum ratios are spelled out in the former internal standards, these are absent from the current standards under consideration. Instead, reference is consistently made to adequate personnel as measured by client records and critical incident reports. It is understood, that clients needs vary irrespective of their setting, and staffing ratios must be flexible to accommodate fluctuations in the amount of supervision required. Similarly, the number of staff alone does not dictate good services. Nonetheless, a minimum ratio helps to assure that a basic capacity is in place.

Staff training is the third major issue pertaining to personnel related standards. The standards do make specific reference to some training requirements, however, time frames, topics, training methods, materials or specific training delivery mechanisms are not detailed for the "disability specific inservice training. A detailed description of the key elements of a training plan are provided in sub-section F. The final issue pertains to overall personnel policies. Little reference is made to the availability of written, personnel policies including: grievance and dismissal procedures, job descriptions, and evaluation and job performance indicators. Again, while this may be generally available to publicly employed staff, this benefit is not necessarily available to privately employed staff. Provision of these materials allows for a clear understanding between personnel and management and reduction of conflicts or abuse of privileges. With respect to general personnel policy, it is important for direct care personnel to be included in client treatment planning as well as overall agency policy. The literature in the field of personnel as well as mental retardation indicates that when staff possess greater decision-making power in their job duties, rates of job satisfaction and tenure increases (Waxman, Carver, & Berkenstock, 1984; Lakin, Bruininks & Hill, 1982). This is a especially important given the often high turnover rates and poor wages associated with community based services for persons with mental retardation.

b. Functionally-Based Habilitative Training

A recent development in habilitative approaches to persons with mental retardation/developmental disabilities is *functionally based training*. This concept differs from the previously accepted model of developmental training. A developmental approach attempts to teach clients an array of skills related to life functioning, but often involves focus on "prerequisite skills." Using this approach, clients may be taught to sort objects to gain needed "prevocational" skills prior to receiving instruction or opportunity related to a real job. Similarly, a client may expend great effort in learning to draw circles in order to eventually sign his name. This approach to training is reflected in several places through the new standards.

Conversely, functionally based training attempts to bypass many so called "prerequisite" skills, targeting only those skills that are required in the actual daily life of the consumer. For example, many clients, even those with severe disabilities, can be taught to work *while* on the job. Likewise, where the consumer has great difficulty learning to sign his name, an "environmental support" approach may be used whereby he may be trained to give his paycheck and deposit slip to a bank teller. An environmental support approach dictates that community staff work with the tellers in the bank to accept the deposit slips and fill them out for the consumer. These alternatives to developmental training permit faster mastery of those skills that can actually reduce the level of supervision the consumer requires and so enhance least restrictive alternatives. Statewide standards are one vehicle by which progressive developments in the field can be filtered into a large state system.

c. "State-of-the Art" Habilitation

This is a general heading to describe a series of linked objectives in consumer programming. Throughout the proposed standards there are references made to key concepts in habilitative programming, such as community integration, age appropriate activities, preparation for least restrictive alternatives and client choice making. It is clear that state planners are well aware of the importance of these ingredients in consumer programs. However, these are broad concepts which can be widely interpreted. Without specific guidelines and examples, these key programmatic objectives can be lost in the detail of facility, documentation, and health and safety regulations. In general, it is easy to implement, describe and evaluate straightforward concepts such as timely referral to services or medication procedures. Consequently, these standards abound with detail. Little detail is offered to describe the broader concepts noted above. In order to operationalize these ideas, state staff need to outline the parameters of acceptable performance, and to articulate examples by which these concepts can be understood and implemented.

Detailed explanatory material that operationalizes these concepts is of especial concern in light of the proposed closure of Bainbridge and GRC. Normalized activities and client choice making may be readily implemented for the relatively less impaired population in the community. However, it is the more disabled populations of the two state hospitals that pose the greatest challenges to service providers who in good faith may wish to implement habilitative programming that respects the rights and dignity of consumers, but who find themselves overwhelmed by the pressing needs of these persons. Again, numerous examples, outcome indicators and measures that describe how normalization and integration can be achieved for a highly impaired population is a necessary component of state-of-the art program standards. Such an approach will not only give service providers guidelines for service provision, but will also communicate the intention, philosophy and priorities of the state.

d. Operationalized Outcome Measures

The final issue pertaining to the proposed standards is use of outcome indicators. The standards consistently refer to outcome measures to be used by the Quality Assurance Team but do not specify what these measures are. Without measures that pertain to outcomes (i.e., client or staff behavior, performance, or capacity), quality assurance is relegated to the measuring of "inputs" in a program, (e.g.. numbers of hours of programming or therapy). Inputs are usually measured through documentation in facility or client records. This can result in quality assurance teams spending hours with documentation not observing the quality of care or training ongoing in the facility. Outcome measures are less resilient on written documentation. For example, rather than measuring social skill habilitation by measuring the number of times that a social relations program is run with a client as is documented, an outcome measure may be the capacity to exchange a four line socially appropriate conversation. Thus, the evaluator can measure program effectiveness by simply speaking with the client. Another example might be a standard pertaining to the presence of a personnel policy. Rather than seeking documentation of the policy, an evaluator can measure the outcome by asking a staff member if they are aware of or can discuss the policy. With thoughtful consideration of outcome measures or indicators of successful implementation of a standard, quality assurance teams and facilities can better understand and measure their success. Standards using this format were recently prepared for some South Carolina facilities serving persons with developmental disabilities (URSA Institute & HSRI, 1987). An example of these standards is included in Appendix E.

2. Licensing

Current personal care home regulations will have to be reassessed to ensure that distinctions in levels of care that are relevant to persons with mental retardation are made among types of residential arrangements, that basic training requirements are included, and that size limitations are addressed.

In order to ensure that licensing standards are complied with, it may also be necessary to expand existing staff at the Office Regulatory Services. Such increases will improve and strengthen the administration of the personal care home rules and regulations.

Finally, the relative responsibilities of the Office of Regulatory Services and the Division of Mental Health and Mental Retardation regarding the regulation of the programmatic aspects of services in personal care homes should be explored. Specific distinctions should be made between threshold, minimum licensing standards and the content of programming delivered in such homes.

3. Monitoring

In order to ensure that there is adequate oversight in an expanded residential system additional monitoring mechanisms will need to be explored. Current licensing reviews and bi-annual quality assurance reviews will not provide sufficient assurance that the well-being of clients is being protected. More frequent and varied monitoring mechanisms will have to be explored including the use of family members in on-site reviews, peer review, national accreditation, and client outcome monitoring.

4. Client Rights

The current internal grievance mechanism is well-articulated and consistent with grievance mechanisms in other states. However, it appears to be little used and not well publicized among families and clients. The state should consider the establishment of an external grievance mechanism that is not tied to the service delivery system.

F. Training and Technical Assistance

1. Staff Training

The results of the provider survey strongly indicate the need for a broadened program of staff training. This need is sharpened by an anticipation of community programs to serve persons with more complex needs.

Exemplary models of staff training and technical assistance must be built upon these seven attributes:

- ***Leadership:*** This element refers to the capacity of persons in a state to spur development of progressive habilitative services. A statewide staff training program offers the opportunity to expose those persons most involved in the provision of services to the state's programmatic philosophy and principles. Leadership in a staff training program is forged through the facilitation of a partnership among state planners, service providers and trainers.

- ***Building on existing resources and experience:*** Persons planning a new staff training program are well advised to utilize existing resources. There are already numerous high quality curricula in various media. These materials can be purchased, copied and adapted. There are also several clearinghouses of training materials in different parts of the country. Other states' experience shows that innovative training delivery mechanisms can be most effective. Some examples are: performance-based objectives, on-site instruction, and competency testing. Similarly other states offer solutions to the administration of training, such as regional proctors and facility-based training proctors.

- ***Flexibility:*** Model staff training programs and curricula are designed to meet the various needs posed by differing service providers and consumer groups. An ongoing method for adjusting curricula to reflect the latest developments in the field is also necessary. Service providers should have some autonomy in selecting those topics and materials most suited to their population and staff training needs.

- ***Incentives:*** Model staff training programs offer a variety of incentives to both staff and service providers. This is particularly useful when a mixed mandated and voluntary training system is used. Incentives may include certification of staff, monetary rewards to individual staff, or rewards to facilities successfully meeting the goals of a training plan.

- ***Use of indigenous training sources:*** There are in Georgia persons with substantial and relevant expertise regarding community-based services. The value of these persons as consultants and staff trainers must not be overlooked. Likewise, in Georgia there are centers of higher education that could offer assistance and could serve to prepare future human service workers. These centers should be utilized to their maximum potential.

- ***Utilization of all funding mechanisms:*** A variety of funding mechanisms can be tapped for statewide training, although Medicaid waiver dollars may be the most reliable source. Sources that other states have utilized are inexpensive community college courses, specific federal training grants, use of senior provider personnel, and inexpensive self-taught training modules.

- ***State-of-the-art habilitative methods*: As mentioned, a statewide training program offers the opportunity to prepare personnel in the most current thinking on habilitative methods. Exemplary curricula offer topics such as: creating and sustaining supported employment, facilitating consumer choice making, emotional and social adjustment, and the aging process.**

2. Technical Assistance

The movement of significant numbers of individuals with severe disabilities will require the establishment of new program models and upgraded program management skills. In order to facilitate such development, it is strongly suggested that the state explore a technical assistance unit within the Division of Mental Health and Mental Retardation. Staff in this unit should be capable of providing assistance to providers who are developing new or expanded services. Such consultation should include programmatic direction as well as program management tools.

Technical assistance should be thought of as an integral part of a comprehensive quality assurance program and should available when compliance problems are uncovered in community programs.

G. Target Populations

As shown earlier, the largest number of persons at GRC and Bainbridge as well as in the community subpopulations in the seven target service areas are found at skill levels III and IV. It may be assumed that this is the case in the other service areas. In other words, the competition for services if GRC and Bainbridge are phased out will be concentrated on those service arrangements appropriate for lower-functioning individuals. In the interest of equity, community acceptance and support, the state may be obliged to plan to accommodate the service needs of at least those individuals having comparable needs awaiting community services along with the needs of those placed out of GRC and Bainbridge.

VII. WHAT ARE THE CONCERNS OF FAMILIES?

A. Introduction

This section presents the results of a survey of the closest relatives of the people living at Georgia Retardation Center (GRC) and Bainbridge The survey was designed to yield an understanding of the satisfaction, attitudes, opinions, and concerns of parents and relatives of the people served in the two facilities.

In prior survey research, families of people in public institutions have been found to be very satisfied with the facilities, and opposed to changes such as community placement. One of the studies was reported by Klaber (1969). Surveying parents of people in institutions in Connecticut, he found more than three fourths of them were convinced of the excellence of the facilities. He concluded that, although the facilities may have been adequate or good, many families believed them to be nearly perfect. In his most radical statement of the findings, he wrote that "the praise lavished on the institutions was so extravagant as to suggest severe distortions of reality in this area."

Later, Brockmeier (1975) reported similarly high levels of satisfaction, coupled with skepticism about community-based care among families of people in Nebraska institutions. In Texas, Payne (1976) discovered the same situation. Payne also identified a "deinstitutional backlash," a loosely knit countermovement of various local and statewide associations of parents organized in support of institutions as opposed to community residential facilities (CRFs). Overwhelming satisfaction was also reported by Willer, Intagliata, & Atkinson (1979) in New York state. At an institution in Pennsylvania, Meyer (1980) found that over 70% of families were satisfied, and they opposed the idea of community placement. The initial findings in the Pennhurst Longitudinal Study were released in 1980, and showed the same pattern (Keating, Conroy, & Walker, 1980). Atthowe & Vitello (1982) detected similar feelings among families in New Jersey. In their survey, 54% expected no more than custodial care, and 91% said the institutional care was adequate or better.

A national survey of families of people living in mental retardation institutions was conducted by Spreat, Telles, Conroy, Feinstein, & Colombatto (1984). The results were in very close agreement with those of the local studies, with a dominant pattern of resistance to community placement.

Although many families of people in institutions see community residential facilities as a viable option for some people, most prefer the institution for their own relatives (Atthowe & Vitello, 1982; Frohboese & Sales, 1980; Payne, 1976). Similarly, Ferrara (1979) showed that parents of children with mental retardation were much more supportive of normalization activities for mentally retarded persons in the abstract than they were for their own children.

Families generally believe the decision to institutionalize their relatives was permanent and final; Atthowe and Vitello (1982) found that 84% of families believed that their child would stay institutionalized for life. Stedman (1977) suggested that deinstitutionalization of a relative with mental retardation forces the family to question whether institutionalization had been appropriate in the first place. To those families who institutionalized their children, deinstitutionalization represents a "painful revisitation" of the original decision (Willer et al., 1979).

The only study to date in which family feelings were assessed before and after community placement was the Pennhurst Longitudinal Study (Conroy & Bradley, 1985). From initially strong opposition, the families changed dramatically. Almost all reported overwhelmingly high satisfaction with the new community based arrangements. This satisfaction was even higher than the high satisfaction they had previously expressed with the institution. Many were extremely surprised at how much their own opinions had changed. They felt that their relatives had made great strides that they had thought impossible, they were pleased with staff, and they perceived their relatives to be happier. They maintained, however, their serious concerns about the permanence of community programs and funding.

The current work builds upon this body of research. The survey reported here only includes the families of people living in institutions. However, if in the future a significant number of people move into smaller and more integrated settings for living and working, the survey reported here can be used as a baseline, just as in the Pennhurst work. In the years to come, Georgia will be able to determine whether families believe the new community services concept is working as well as the old institutional concept did.

B. The Role of Families in Service Provision

In a formal sense, the individual service provision process generally places the family in the role of permission-giver. Service programs do not regularly contact families unless some form of consent is needed, such as for medical treatment. Conversely, the family rarely makes contact with program officials (other than direct care staff seen during visits) unless they perceive a serious problem. Although the annual inter- or trans-disciplinary Individual Habilitation Plan process is intended to include consumers and families, reviews of attendance records of such meetings tend to reveal limited success in this aim. The once-a-year notifications of upcoming meetings are often insufficient enticement to draw families into an arena dominated by professionals speaking incomprehensible jargon. Even when a family member does attend, his or her role often reduces to permission-giver. The professionals must convince the family member to sign the plan after they have agreed among themselves about the content.

The role of most families in the overall policy making process, in setting directions for years of future service system development, is even more limited. Some vocal and articulate families, and particularly those affiliated with a well organized group such as an Association for Retarded Citizens, have successfully gained access to the decision making process. Such families are in the minority. The majority of families are not so active, articulate, and affiliated. They may become so, however, when a new policy initiative is perceived to threaten any of the services they believe to be important for the well-being of their relatives. It is therefore essential for policy makers to obtain frequent and representative readings of the attitudes of this family constituency. Otherwise, several things are likely to happen:

- Only the vocal and powerful families are in a position to advise about the impacts of proposed actions, and these families may not be in accord with the majority;

- For the most part, the only time officials hear from most families is when something has gone wrong. In other words, the only news officials get from families is bad news. This cannot have a positive influence on mutual regard in the long run;

- Officials never know how satisfied the average family is with the services rendered;

- A "sleeping giant" phenomenon may surface unexpectedly in response to a new policy.

In order to create a dignified and valued role for families at all levels of the service delivery process, one of the simplest and most economical beginnings is to include families as part of the quality assurance loop. In the past, the most widely known and used quality assurance practices, which focus on settings rather than individuals, have ignored families. Neither the standards of the Accreditation Council for Persons with Developmental Disabilities, nor those of the federal Intermediate Care Facilities for [people who are] Mentally Retarded, define a clear role for families during site reviews.

Moreover, nearly every state requires some variety of state or local licensing for service facilities, but we are aware of none that require input from families.

Simply polling the families regularly about general and specific issues is a straightforward way to begin. As families begin to receive evidence that their views are being listened to, positive feelings may increase and involvement may become more productive. Extreme situations and emergencies must be investigated rapidly. Formal mechanisms for hearings of grievances are needed. Statements of general problems repeated by many families must be made the subject of well publicized policy initiatives. Finally, as individually oriented (rather than setting oriented) quality assurance activities evolve, families must be accorded a role that includes the opportunity to visit and evaluate services rendered to people in both residential and day settings (Provencal & Taylor, 1983).

This report presents the results of the first statewide attempt to survey the families of all the people living at GRC and Bainbridge. It represents a positive step toward enhanced and diversified mechanisms for family involvement in service provision.

C. Methods

The items on the Georgia Family Survey questionnaire are included as part of the Results section of this report. The questionnaire was developed jointly by the consulting study team at Conroy & Feinstein Associates (CFA) and the Division of Mental Health, Mental Retardation and Substance Abuse. As starting points, the group used questionnaires developed for the Pennhurst Longitudinal Study and the Applied Research Project of New Hampshire. Some items were deleted, and some new ones were written. The final questionnaire asks the family's opinion about the quality of the care received by their relatives, how happy they think their relatives are with their situations, attitudes about major issues in the field, and major concerns. Every effort was made to avoid jargon and to use a vocabulary level comprehensible by the majority of the American public. There were 27 questions on the survey, and it was designed to take an average of about 15, but never any more than, 30 minutes. The survey packages were mailed out with a cover letter from the Division explaining the purpose of the project, a survey form, and a stamped envelope in which to return the survey form.

The Division had lists of all primary family contacts of the residents of both facilities. Outsiders such as the consulting study team should not be given the confidential names and addresses of relatives unless permission is given. In order to obtain permission, a mailing to all families would have been necessary. Therefore it was most sensible for the Division to mail out the survey packages directly. The fact that a family filled out a form and mailed it to CFA constituted the family's permission for CFA to obtain its opinions.

D. Results

1. The Family Respondents

In July 1987 when the family survey was mailed out, records maintained by the Division indicated that 390 people lived at Georgia Retardation Center (GRC). A total of 402 survey packages were mailed, because 12 people had divorced parents, both of whom received packages. Also among the 402 were 17 packages that went to guardians, because no family member was available. (In this report, we will continue to use the term 'family' for simplicity, even though guardians are included.) At Bainbridge, there were 196 people in residence, and 188 packages were mailed out, because there were 8 people with no known families. Thus a total of 590 survey packages were mailed out.

After the packages were sent out, some were returned for bad or expired addresses. August 22 was the last day on which we were able to receive a completed questionnaire and still have time to perform editing, data entry, and include it in the analysis. On August 22, we had received a total of 308 valid questionnaires. If bad addresses are ignored, this is an overall response rate of 52.4%. This is similar to the response rate obtained in community surveys in Pennsylvania (about 50%), and to our Connecticut surveys across all types of service settings (50%). It is higher than that obtained in CFAs national institutional family survey (36%). The Georgia response rate would be typical of community or mixed service settings, but it is higher than that normally expected for institutional settings.

The responses from GRC families numbered 194. Out of 402 packages sent out, the GRC response rate is 48.3%. For Bainbridge, 113 responses were received to 188 packages, for a response rate of 60.1%. We infer that the Bainbridge families were significantly more motivated to respond to this questionnaire.

In the tables that follow in this report, the questionnaire responses are broken down for GRC in the first column and Bainbridge in the second. For items that are best treated as scales, such as the 1-to-5 point satisfaction items, the results are simply reported as average scores. For items best treated as categorical data, such as relationship, the two columns of numbers given are the percentages of the respondents who fell into each category.

The questionnaire included two items on the characteristics of the family respondents: relationship and age group. The relationship of the respondents to the individuals who live in the facilities is presented in the following table.

Percent of Families

(1) How are you related to this person?

	GRC	BAIN.
1. Mother	46	35
2. Father	11	15
3. Mother and Father (responding together)	26	20
4. Sister or Brother	6	12
5. Guardian	5	11
6. Other	6	7

For both facilities, mothers were the most frequent respondents. Somewhat fewer of the Bainbridge respondents were mothers, and the difference was spread out in the father, sibling, and guardian categories. This is probably attributable to the fact that the average Bainbridge resident is older. It follows that fewer parents are still living.

The respondents tended to cluster in the 40 to 69 age brackets, and showed a similar distribution for the two facilities, as shown below.

(26) About how old are you?

1. 20 to 29	3	1
2. 30 to 39	12	13
3. 40 to 49	25	30
4. 50 to 59	23	14
5. 60 to 69	23	23
6. 70 to 79	11	15
7. 80 or over	3	3

2. Characteristics of the Relatives

Several items asked the respondent to describe the characteristics of the relative: level of medical needs, level of retardation, other disabling conditions, independence, and challenging behaviors. The respondents' perceptions of the level of need for medical care is tabulated below.

(2) How urgent is your family member's need for medical care?

1.	Would not survive without 24-hour medical personnel	29	14
2.	Has life-threatening condition that requires very rapid access to medical care	18	7
3.	Needs visiting nurse and/or regular visits to the doctor	11	15
4.	Has medical problem that needs medical attention from time to time	28	45
5.	Generally has no serious medical needs	14	18

The pattern is clearly different for the two facilities, with families reporting much more intense medical needs among residents of GRC. Almost half are reported to have very serious needs. Although the comparison between facilities is undoubtedly valid, the absolute magnitude of family estimates of medical needs should be treated with caution until checked against other sources (Conroy, Feinstein, Lemanowicz, & Kopatsis, 1985). The reports from the Bainbridge families strongly resemble those received from families of Pennhurst class members, all of whom are presently living in community settings. The GRC figures, however, suggest that this is a very different kind of population in terms of the need for well designed medical services and backup.

Similar caution should be exercised with regard to family usage of level of retardation labels (Conroy, in press). Families tend to underutilize the label 'profound,' often substituting 'severe.' Nevertheless, the comparison between facilities in the table below is very likely to be accurate.

(3) What is your family member's level of mental retardation?

1.	Not mentally retarded	2	8
2.	Mild	4	5
3.	Moderate	12	16
4.	Severe	43	52
5.	Profound	39	19

People at GRC are much more likely to be labeled "profound" by their families than are people at Bainbridge. It would be interesting to compare these 'family labels' to 'professional labels' at the two facilities. However, the overall frequency of the 'severe or profound' levels (82% at GRC and 71% at Bainbridge) are likely to be quite accurate, and are almost exactly what one would expect in facilities of the two types in the 1980s (Hill & Lakin, 1984). Facilities in Pennsylvania, Connecticut, and New Hampshire in which the study team has worked in recent years all displayed rates between 80% and 85%.

The next table presents the percentage of people who were reported to have additional or related disabling conditions.

(4) What other condition(s) affect your family member? (PLEASE CIRCLE ALL THAT APPLY)

1.	Autism	8	4
2.	Blindness	14	8
3.	Cerebral Palsy	15	4
4.	Brain or neurological damage	62	42
5.	Deafness	10	5
6.	Epilepsy	23	23
7.	Mental Illness	26	33
8.	Other (specify)	10	8

The table shows three major differences between the facilities. First, the people at GRC are much more likely to have sensory and physical deficits (blindness, deafness, cerebral palsy). Second, they are much more likely to be reported to have brain or neurological damage. Both of these facts are consonant with the facility's reputation of serving people with multiple handicaps and with the ICAP data described earlier. Third, the Bainbridge people are more often reported to display mental illness, which fits with the facility's reputation of specializing in people with challenging behaviors.

The next table shows clearly the difference in functional abilities of the people who live in the two facilities. Because of the family tendency to avoid the 'profound' label noted earlier, this table is probably more accurate than the level of retardation labels.

(5) How well developed are your family member's self-help skills?

1.	Very well developed. Can function independently	0	3
2.	Well developed. Needs help only occasionally.	6	4
3.	Moderately developed. Needs supervision	22	28
4.	Poorly developed. Needs help most of the time	20	30
5.	Very poorly developed. Needs help with nearly all tasks	52	35

The table again shows that people at Bainbridge are perceived to be higher functioning than the people at GRC. The fact that this is actually the case supports the notion that the survey data are valid.

The next two items asked about self-injurious and outer-directed challenging behaviors.

(6) Is your family member harmful to him/herself?

1. Never or rarely	66	31
2. Occasionally (once a month)	12	25
3. Weekly or more often	5	9
4. Daily or more often	5	4
5. Constantly unless closely monitored	12	31

(7) Is your family member harmful to others or to property?

1. Never or rarely	63	30
2. Occasionally	20	41
3. Weekly or more often	4	6
4. Daily or more often	3	5
5. Constantly unless closely monitored	9	17

The data clearly show that the Bainbridge people are much more likely to display such behaviors. Self-injurious behaviors that occur daily or constantly are reported almost twice as often for Bainbridge as for GRC people, and the same is true for outer-directed challenging behaviors.

3. Satisfaction With Services and Perceptions of Happiness

There were three questions about the families' level of satisfaction with the services received by their relatives. All three were on 1-to-5 point scale, with "1" meaning "Very satisfied" and "5" meaning "Very dissatisfied." The figures shown in the following table are the average satisfaction ratings given by the families.

	GRC	BAIN.
(8) Overall, how satisfied are you with the place where your family member is living?	1.5	1.4

(9) Overall, how satisfied are you with what your family member does during the day? (Day program, school, or work) 1.6 1.4

(10) How satisfied are you with what your family member does on weekends? (Leisure and recreation) 1.9 1.6

The answers to item #8 show very high levels of satisfaction with the residential settings at both facilities. In all, 72% of families gave the rating "Very satisfied" and only 1% reported themselves to be "Very dissatisfied." These families could be identified if GDHR wishes to find out more about these individual cases of dissatisfaction. In Pennsylvania community programs, 68% of families gave the "Very satisfied" rating, and under 1% gave "Very dissatisfied."

Item #9 is about the day programs, and satisfaction is almost as high as for the residence; 66% rate "Very satisfied" and only 2% rate "Very dissatisfied." The Pennsylvania figures are 35% and 1% respectively. On item #10, satisfaction with weekend activities is somewhat lower, with 53% rating "Very satisfied" and 2% rating "Very dissatisfied." This question was not asked in Pennsylvania. In all three areas, the ratings given by Bainbridge families indicated slightly higher satisfaction than GRC families.

Two other items obtained the families' opinions about the happiness of the relative.

(11) How happy do you think your family member is with his/her living situation? 2.1 2.1

(12) How happy do you think your family member is with what he/she does during 2.2 2.1

Again, the answers were on 1-to-5 point scales, with "1" being "Very happy." On item #11, the general opinion is that people are "Happy" with their living situations. However, 1% were reported to be "Very unhappy" and another 4% were reported to be "Unhappy" with their living situations, and, if desired, these cases could be identified for further investigation of the situations. Item #12, about the day program, is similar. Most responses are divided evenly across "Very happy," "Happy," and "Neither happy nor unhappy." Another 2% are reported to by "Unhappy," but 0% are rated "Very unhappy."

4. Frequency of Visits

The frequency of family visits differed sharply between the two facilities.

(13) How often were you able to visit your family member in the past year?

1.	About once a week or more	32	3
2.	About once a month	31	24
3.	About every 3 months	19	24
4.	Once or twice	11	24
5.	Not in the past year	7	25

(14) How often did your family member come to visit you in the past year?

1.	About once a week or more	11	1
2.	About once a month	19	7
3.	About every 3 months	9	11
4.	Once or twice	9	17
5.	Not in the past year	41	64

The visitation reported by GRC families resembles that reported by families of Pennhurst class members in community settings, half of whom say they visit their relatives at least monthly. The GRC families report even more frequent contact, over 60% visiting at least monthly. For 9% of Pennhurst families, the answer was "Not in the past year," close to the 7% reported by the GRC families. The GRC residents are younger on the average, which may explain the somewhat higher visitation rates. (In the Pennhurst study, we did not detect any increase in family visits after community placement.)

The Bainbridge visitation pattern is strikingly different. For a set of reasons that probably include the behavioral component of the Bainbridge residents' disabilities, the relative isolation of the facility, and the age of the residents, visitation is less frequent than in almost any other setting we have measured. (The exception is homes for the aged, and in this case siblings are often the closest relatives. They do not typically visit often.)

The results for visits of the individuals to the families' homes are precisely parallel. The GRC families are similar to Pennhurst families, and the Bainbridge families are unusually inactive in this area.

In a related question, families were asked about their preferences. Because it seems likely that travel distance may have a strong effect on the likelihood of visits, the question asked how close the family would like the disabled relative to live.

(15) How close to your home would you like your family member to live?

1.	Fifteen minutes or less	23	10
2.	Thirty minutes or less	35	15
3.	One hour or less	25	27
4.	Two hours or less	5	18
5.	Doesn't matter	12	30

Again, the pattern indicated a strong difference between the GRC and the Bainbridge families. Many GRC families seemed to feel that distance was an important issue, but the figures were very different for Bainbridge families, 30% of whom said it "Doesn't matter." These results regarding visits and preferences suggest that family cohesiveness has largely vanished for people at Bainbridge, and, in cases in which continued family support and encouragement might be important for the individual, this may be a problem in need of attention.

5. General Opinions

Two questions explored the confidence of the families, specifically in the areas of the relative's probability of learning more skills and in the ability of staff to handle anything that comes up. In these areas, the GRC and the Bainbridge responses were similar and in general they expressed neutral opinions (half optimistic, half pessimistic) about the possibility of development.

(16) My family member has learned just about all he/she is ever going to learn about taking care of his/her own needs. 3.2 3.4

(17) I trust the ability of the staff who work with my family member to handle almost anything that comes up. 3.9 4.2

These average ratings on the learning item suggest that the typical family tends to agree with the idea that no more learning is possible for the relative. This has been found in several other states, and across settings, and calls for consideration of increased family education and training opportunities about new technologies and new hopes in the field of mental retardation. Item #17, about confidence in the facility staff to handle anything, shows high levels of confidence, and the expressed confidence is slightly higher among the Bainbridge families.

6. Concerns

The questionnaire listed eight issues and asked families to rate each with regard to how great a concern it was for them. Each item was answered by choosing a number from "1" to "5," with "1" meaning "Hardly concerned at all" and "5" meaning "This is one of my greatest concerns." Thus the higher the number the greater the degree of concern expressed. The items have been sequenced according to the average level of concern rating given. The sequence is the same for the two facilities.

FIGURE 46: FAMILY CONCERNS

MEAN SCALE SCORES

HOW CONCERNED ARE YOU ABOUT THESE ISSUES?	GRC	BAIN
PERMANENCE (19) How long the agency that serves my family member will be in business.	4.6	4.1
CONTROL (25) Whether I will have a major say in what happens to my family member.	4.3	4.1
SAFETY (23) The ability of the state and county to maintain a safe and secure environment for my family member.	4.2	3.7
MONITORING (22) The ability of the state and county to monitor the quality of the settings and take action against bad programs and against client abuse.	4.1	3.7
RATIO (24) Whether there are enough staff on duty at the program.	4.1	3.7
MEDICAL (20) The ability of the agency to assure that my family member gets good medical care whenever needed.	4.0	3.5
BEHAVIOR (21) The ability of the agency to handle behavioral emergencies, such as a serious outburst from one of the people living there.	3.7	3.5
TURNOVER (18) Staff turnover in the place where my family member lives (how often staff leave and have to be replaced).	3.6	3.0

For convenience of reference, the same information is presented in the bar graph on the following page entitled "FAMILY CONCERNS: Responses of GRC and Bainbridge Families." The concerns that are given the highest ratings seem to be at the level of the basics: permanence, control, and safety. For families of people in community programs in

Pennsylvania, the sequence of concerns is somewhat different: control, monitoring, and permanence.

As is easily seen in the graph, the GRC families express higher levels of "concern" about every one of these issues. This suggests that there is some reason to believe that the GRC families are, in general, more worried about their relatives and their future.

E. Discussion

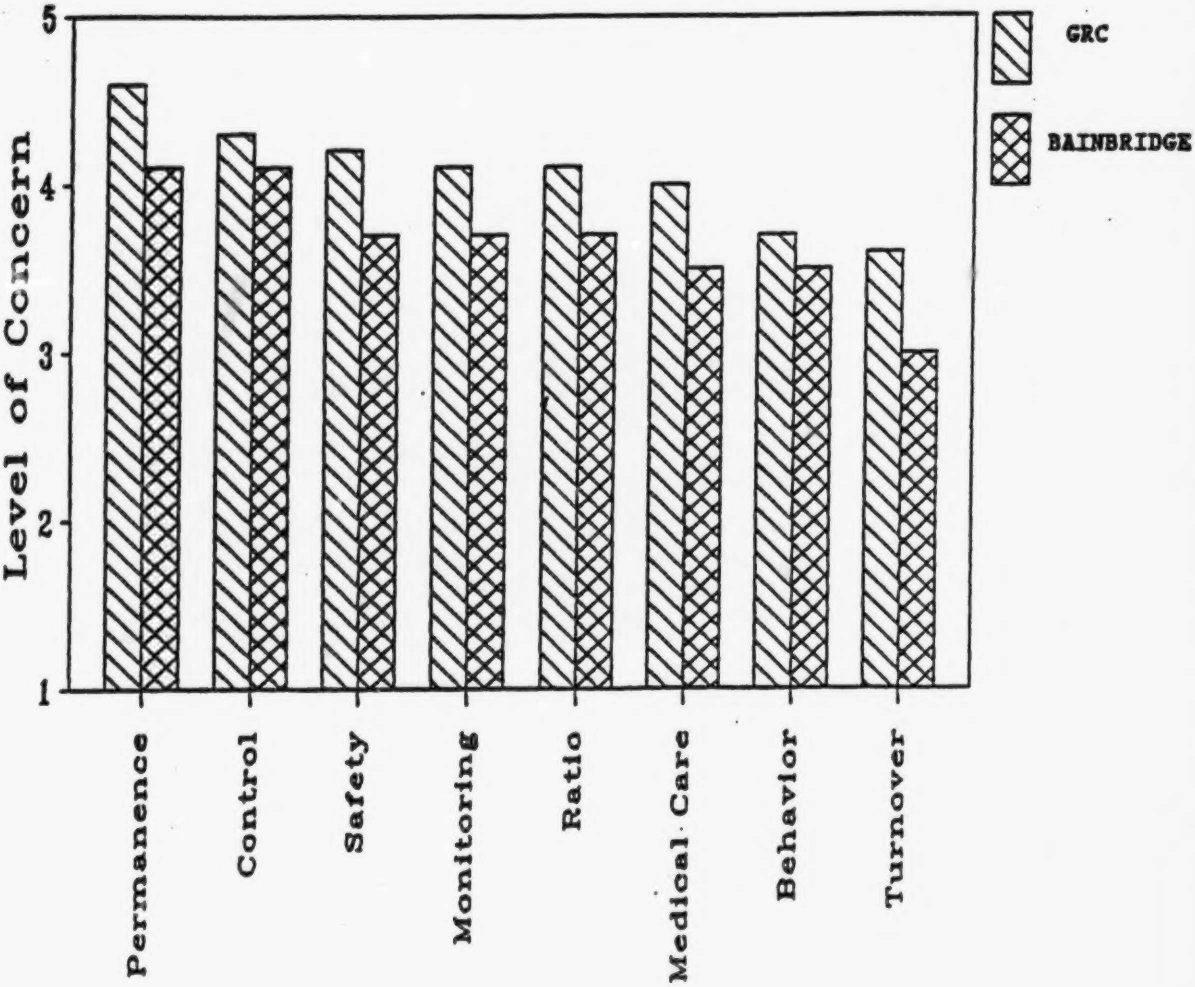
It seems very clear that the family survey process is valuable and informative. It is also important to note that family surveys are very easy and inexpensive to perform. The overall response rate of 52%, with no second mailing or followup, is very good. In past work on non-respondent bias (Conroy & Bradley, 1985), we found that there were no significant differences in the characteristics and satisfaction of families that did respond from those that did not. We therefore have good reason to believe that the 52% response rate is more than adequate to represent the feelings of all the families.

Overall, families of people at GRC and Bainbridge are extremely satisfied with their living situations, and also with their day programs. Most families also believe that their relatives are happy with their living and day program situations. Almost none of the families think their relatives are unhappy with either aspect of their lives.

Families' concerns seem to focus largely on the basics: how permanent is the facility, how much control will the family ultimately have, and will the relative be kept safe in his or her environment. Interestingly, the families generally believe their relatives are incapable of further behavioral progress or skill acquisition. They are very confident in the staff of the facilities.

These data will enable future evaluation of changes in family attitudes and perceptions. Whether people continue to receive service in a congregate care environment, or whether they move to smaller, more integrated community settings, the ability to evaluate these changes over time will be a crucial element of the overall evaluation of the impacts of any changes in the service system.

FIGURE 47: FAMILY CONCERNS:
RESPONSES OF GRC AND BAINBRIDGE FAMILIES



PART TWO

This second part of the Georgia Feasibility Study describes what will be required to create alternative community residential and day settings for persons currently living at Georgia Retardation Center and the Southwest Developmental Center at Bainbridge. The first section outlines the necessary policy and systemic changes that will be needed. The second portion addresses those steps that will be required to ensure adequate direct care, managerial, and specialized staff to provide community-based services. The third section describes the range of services that will be needed to serve the target population and the costs of initiating and operating such services. The fourth section discusses the elements of a transition plan for clients as well as a management transition strategy. The fifth and final section highlights a sequence of activities that should comprise the implementation of the phase down at the two facilities.

I. WHAT SYSTEM CHANGES WILL BE REQUIRED?

If a decision is made in the State of Georgia to proceed with the closure of GRC and Bainbridge, a number of system changes will be required to support the expansion of community services and to reinforce the administrative infrastructure. Except for cluster management, cost estimates for which are included in Section III, the budget implications of these administrative change recommendations are not assessed.

A. Administration

To ensure that the expansion of community services is accomplished in an expeditious and planned fashion, additional administrative tools will be required. Managing the process of deinstitutionalization involves the initiation of multiple and sequenced activities. It also involves oversight over a growing network of services whose clients have disabilities that are serious and profound. The following discussion lays out some of the administrative activities that will be necessary at the state and local level to bring about the change.

1. Expand Private Sector Involvement

To develop the magnitude of resources needed to provide alternative residential and day settings for individuals currently residing at GRC and Bainbridge within a reasonable time-frame, more private sector involvement will be required. This observation is based on variety of factors. First, several of the key informants interviewed for the study agreed that private sector resources would be necessary to expedite the expansion of community services. Second, the expansion of private sector services should result in increased diversity and programmatic approaches. Third, the private sector should be able to move more expeditiously to create services given the personnel procedures that must be followed by public providers. Finally, encouraging more private sector services will bring additional expertise into the service system.

Since the current system relies heavily on publicly operated day and residential programs, changes will be required to administer expanded private sector contracts and to ensure that private sector development proceeds according to state and local implementation plans. The following guidelines are proposed:

- Contracts with private providers should be directly with local health boards in order to ensure the responsiveness of the provider to local needs (exceptions to such arrangements are discussed in the section that follows: 2. State Responsibilities);
- Standardized contracting formats should be designed by the state in order to ensure uniformity of legal relationships;
- Indigenous provider organizations should be encouraged and supported;
- Criteria for the selection of providers should be developed including the preparation of an RFP process and the creation of a pre-contracting screening process to ascertain financial viability and stability.
- In addition to the participation of private corporate entities, specialized family care (similar to the models developed at Macomb-Oakland in Michigan) should be developed to accommodate the increased demand for residential arrangements. This will require a dedicated program manager within the Division.

2. State Management Responsibilities

An expanded community system -- especially one that relies more heavily on private providers -- will place additional responsibilities on the state insofar as oversight and accountability are concerned. The powers that the state currently has over the provision of services need to be sharpened and made more explicit to ensure that necessary actions can be taken quickly and forcefully. Specifically, we recommend the following:

- The state should develop a *receivership* statute which makes it possible for the state to take over the operation of a provider that has either failed to comply with quality assurance mandates or has faltered financially. Several other states around the country have developed such laws and have begun to apply them.

- Specific guidelines should be developed to trigger state involvement in the provision of services in a mental health, mental retardation, substance abuse service area. While the state currently has the ability to provide services in an area where a local health board has declined, intervention short of actual rejection of funds by a local health board is less clear. In order for deinstitutionalization at GRC and Bainbridge to prove feasible, local service areas must evince the capability to develop resources within a prescribed period of time. Specific criteria must be developed to determine the level of local capacity and the point at which it is incumbent on the state to intervene to ensure that needed services are developed.

- A state resource development team should be created to assist in the initiation of private sector services (See Section V).

3. Data Management

Under the capitated system of funding proposed in Section III of this part, local program managers will have much greater latitude to shape the local service systems to individual client needs. To do so in a cost effective fashion will require bolstering the information systems in most areas to include better information on client levels of functioning, related service needs and costs. The information on service requirements would most logically derive from the client individualized habilitation planning process.

4. Local Resource Development

The process of developing individualized community services for persons currently residing at GRC and Bainbridge and ensuring that both natural as well as specialized supports are available will be crucial to the success of a deinstitutionalization process. It will be necessary to designate individuals within each service area who can carry out this responsibility. This concept has already been piloted in some MH/MR/SA service areas in the state and has come to be called *cluster management* (See: Mount and Puckett, 1986). A cluster is a group of clients with similar needs. [Note: The term "cluster" as used in this context should be differentiated from facility "clusters," a term used to describe long-term care facilities in some states.] Cluster managers work with Mental Retardation Specialists who, in many areas of the state, have become system managers and no longer have sufficient time for individual resource development.

Cluster managers are responsible for deciding on the level of staffing, type of housing, and selection of roommates; managing resources; supervising sites and staff; and designing programs. They also work with neighbors, friends and family to ensure maximal community integration. The mission of the cluster manager is to develop flexible and dynamic service settings and supports rather than to match clients to pre-determined options.

Within the deinstitutionalization effort, cluster managers would be responsible for becoming familiar with clients before they leave the institution, working with the case manager and the individualized planning team, securing the confidence and participation of the family, organizing access to a primary health care provider, and exploring individually-tailored support possibilities.

B. Quality Assurance

In Part One of the study, the importance of quality assurance was underlined and the state's current and proposed quality assurance procedures were reviewed. As noted, quality assurance is a critical element in the provision of services to individuals with severe disabilities -- especially in a decentralized and scattered system and one that may rely more heavily on private providers of services. Quality assurance systems also communicate the state's programmatic vision and values with respect to design and management. The state has already taken several important steps to improve its current QA system including the development of comprehensive standards and the planned

Title XIX case management system. This section describes specific activities that will enrich those systems.

1. Standards

Based on the analysis presented in Part One, the following expansion of the proposed consolidated quality assurance standards is recommended:

- Minimum standards should be developed for staff of day and residential programs including minimum age limits (i.e., 18 years and over), educational minimums and other qualifications. The state may also want to consider a statewide certification program for direct care staff;
- Minimum staff/client ratios should be spelled out to ensure basic capability;
- The content of staff training should be specified in standards including the frequency, duration, and topics covered.
- Standards should be developed that address agency personnel policies including provisions for grievance mechanisms as well as staff participation in agency decisions;
- The standards should be revised to encompass *functionally-based training* principles rather than developmentally sequenced learning;
- Client outcomes and accomplishments should be included in the quality assurance process as indicators of agency performance and appropriateness of service intervention.

In addition to the revisions noted above, there are two additional areas of standard setting that should be addressed. The first has to do with the provision of health services. Standards for health services should include topics such as access, informed consent, information sharing, frequent reviews of drug regimens, and personnel qualifications.

The second area has to do with the development of standards to govern the creation of specialized family care homes where one or two persons with mental retardation may reside. Such homes, included in the feasibility projections discussed in Section III, are more than simple foster care and involve the provision of substantial training and technical assistance to the home provider. To assure that such homes meet these expectations, standards for performance will be required.

2. Licensing

As discussed in Part One, the major licensing category that governs virtually all residential arrangements for adults with mental retardation is personal care homes. Based on the analysis conducted for this study and other studies conducted in the state (See: Murray, 1986), there are a variety of changes needed in the regulatory process to facilitate the development of responsive residential services for persons with mental retardation:

- An upper limit on the number of beds in personal care homes serving individuals with mental retardation should be fixed at six;

- Specific categories of personal care homes based on the nature of the needs of residents should be established;

- Minimum standards for operators of personal care homes should be developed;

- Additional staff should be made available to ORS to assist in the implementation of personal care rules and regulations. Such staff should be available to conduct inspections of new providers when the local sanitarians are unable to respond in a timely fashion;

- Interagency discussions should be held between the Division of Mental Health, Mental Retardation and Substance Abuse and the Office of Regulatory Services to distribute responsibility for the development of programmatic and content standards on the one hand, and threshold facility and basic capacity standards on the other hand.

3. Monitoring

The proliferation of community-based services for persons with severe disabilities requires an intensified monitoring effort to protect the well-being of these more vulnerable clients. To be successful, monitoring should be comprehensive and multi-faceted and should occur at numerous junctures throughout the program year. In addition to the Division's proposed quality assurance reviews, we propose the following additional monitoring activities:

- The Division should encourage the creation of family monitoring teams around the state to conduct periodic on-site observations in residential and day services. Models for such monitoring can be secured from the State of Ohio as well as from the Macomb Oakland program. The use of family monitoring mechanisms is particularly important in light of the concerns expressed by family members in the family survey (See Part One, Section VII). Involving families in monitoring activities should help to allay some of their anxieties regarding the transfer of their relatives to community programs.

- Client satisfaction inquiries should be designed to solicit the input of consumers of services regarding the efficacy of services. While not all individuals can verbally articulate their feelings about their service experience, techniques should be developed to solicit the views of those who can communicate.

- Family satisfaction with services should be routinely canvassed as part of any quality assurance system.

- The Division should explore the use of peer review teams as a supplement to other monitoring activities to conduct programmatic assessments around the state.

- Client growth and development should be routinely monitored through the use of standardized assessment techniques.

4. Client Rights

The state currently has a well articulated internal client grievance mechanism. As with such systems in many other states, it is not used with much frequency. To make this avenue a more viable option for clients and their friends and family members, local health boards need to find ways to publicize the availability of the grievance mechanism and to train providers and others regarding the access procedures.

In addition, the Division should explore the possibility of establishing an external complaint resolution mechanism that is not bound to the service delivery system. Such an option could be made available in instances where the appropriateness of a placement is at issue or when the adequacy of services is in question. The existence of an external grievance system would also serve to allay the fears of family members regarding potential problems in the community system. Specifically, the Division could examine the expansion of the human rights committee mechanism used in institutions and/or the increased involvement of the Georgia Advocacy Office.

C. Family Involvement

Conversations with family members of individuals at GRC and Bainbridge and the results of the family survey reinforce the importance of involving families at the very beginning stages of any planned changes in the family member's living arrangement. One important reason is that family members in many instances have knowledge about their relatives that professional staff may not have. Further, early involvement minimizes family misunderstanding and anxiety. We therefore recommend that the following procedures be developed:

- The implementation plan for the phase-down of the two facilities should be shared with affected family members as soon as it is available;

- Initial meetings should be held with families to discuss the needs of their relatives;

- Family members should be included on the planning team convened to develop resources for their family member;

- Family members should have the right to appeal their relative's placement plan if they disagree with the nature of the service proposed and to secure a review at the Division level;

- Family members should be included on any steering committee established to guide implementation of the phase-down;

- As noted above, family members should be included on local program monitoring teams and should be routinely canvassed regarding their satisfaction with services received by their family member.

D. Community Acceptance and Zoning

As discussed in Section A above, additional private providers will be required to facilitate the expansion of community services necessitated by the phase-down of GRC and Bainbridge. Accelerated development will also be required in publicly operated services. To assist and expedite such development, it will be necessary to design an overall plan for gaining access to local communities both insofar as community acceptance and for overcoming potential zoning constraints.

1. Community Acceptance

The discussion in Part One indicates that one approach to locating group homes and other community living arrangements in residential neighborhoods is to delay indepth community education activities until the home is established. At that point, neighbors can be invited to the house, through an open house, for example, to meet the occupants (Seltzer, 1984; Conroy & Bradley, 1985). This approach can be supplemented with other strategies such as involving community leaders and neighbors as staff and as board members (Seltzer, 1984; Smith & Jaffe, 1986).

Healthy relationships with neighbors and community receptivity towards persons with mental retardation are also enhanced when the attractiveness of the property is maintained (Smith & Jaffe, 1986). With proper maintenance property values will increase. Maintaining the attractiveness includes taking proper precautions so that adequate parking is provided for staff and residents.

Other strategies, useful in accessing single family neighborhoods for group home development, include relying on uniform state requirements that would supersede local zoning authorities (Ibid. 1986). Another vital approach entails scattering the group homes or community living arrangements throughout the neighborhood to prevent clustering of facilities in particular areas. This strategy is critical in order to maintain good relationships with neighbors and to maximize opportunities for community integration.

A further factor in maintaining positive relationships with neighbors concerns the provision of adequate programmatic support so that staff and residents can move comfortably in the neighborhood and can interact with neighbors. Opposition to community residences increases when neighbors have negative experiences with residents who are not receiving assistance which is adequate to meet their needs. On the other hand, positive changes in attitudes can result when neighbors have beneficial direct interactions with residents.

Adequate programmatic support consists of accessing or providing comprehensive, community-based services to residents. These services include generic programs such as educational, vocational, health, diagnostic and counselling services. Planners must also anticipate and provide resources necessary to meet the increased demand for services in the community.

Providing adequate programmatic support also entails anticipating the diverse array of services needed by persons who have greater independence. The supports necessary for these individuals to live more independently include providing assistance with home maintenance, hygiene, nutrition, budgeting and using community services. Enhancing the quality of life for persons who are living more independently is contingent upon experiencing exchanges with the community.

In conclusion, maintaining positive attitudes among neighbors is an ongoing process. This process begins with the selection of neighborhoods which are safe, primarily residential and have a balance of rental and owner-occupied housing. Additional siting considerations include the proximity of the home to public transportation, shopping, community support and recreational services. Following the opening of the home, the next critical issue is the gradual exposure of neighbors to residents and staff managing the home and, finally, the continual improvement and maintenance of both the property as well as the provision of adequate support for the staff and residents.

In addition to this overview of national experience, the Georgia Developmental Disabilities Council also sponsored a study that addresses community acceptance issues (Murray, 1986). The report, titled *Issues of Quality: A Study of Community Residential Alternatives*, reviews some of the activities that have been launched in the state to address the problem of community attitudes and also makes some recommendations. Specifically the report recommends that community residential services staff need to have a better appreciation for and skills in the area of community relations and community resource development. Regional training workshops and follow-up technical assistance are suggested.

Those interviewed as part of this project also suggested that a move away from a "facility" orientation and toward an individualized and

flexible support model might help to "humanize" the service system and to make it more understandable to the general public.

2. Zoning

During the course of the feasibility study, several interviewees noted the problems confronted by private providers in particular in overcoming local zoning barriers. Again, assuming that more private providers will be required to facilitate deinstitutionalization at GRC and Bainbridge, zoning obstacles will have to be confronted in a systematic fashion at the state level.

In some states, litigation has successfully overcome such local zoning constraints. Specifically, courts in other states have found that private providers paid with public funds to carry out statutory mandates share the same immunity from local zoning requirements that is granted to publicly operated facilities. Similar litigation before the Supreme Court in Georgia, however, resulted in a contrary decision that failed to find any legislative intent for such immunity (Macon Association for Retarded Citizens v. Macon Bibb County Planning and Zoning Commission, 1984).

Another means of overcoming local zoning barriers is through the passage of overriding state legislation. To date 34 states have passed some form of legislation authorizing, to varying degrees, the establishment of group homes in residential zones. In a recent review of zoning issues around the country, Lester Steinman (1987) describes six non-mutually exclusive categories for sorting these state zoning laws:

1. Statutes establishing group homes as a permitted use in all residential zones, either expressly exempted from the imposition of local zoning restrictions or subject only to those restrictions that are otherwise applicable to single family residences.

2. Statutes differentiating between smaller and larger population group homes, with the smaller (six or few) being treated as a single family residence permitted in all residential zones and the larger (seven or more) permitted in either all or only multi-family residential zones with varying degrees of local control by special permit.

3. Statutes authorizing group homes in residential zones either without expressly limiting the power of political subdivisions to

impose special permit requirements or affirmatively preserving such local land use power.

4. Statutes differentiating between types of permitted residents in group homes or between public and privately operated group homes.

5. Statutes where a group home is either considered a family or deemed a residential use but municipality has potential veto power over site selection.

6. Statutes mandating or encouraging that group homes be permitted within municipalities but preserving local autonomy regarding the determination of the appropriate district and the conditions to be imposed upon such use.

There has been some discussion in the state of introducing legislation to reinforce the state interest in providing community services and to designate private providers of such services as instrumentalities of such state intent. The language of the proposed statute is presumably addressed to the Georgia Supreme Court decision which found that a sufficient statement of intent is missing in the current Georgia Community Services Act for the Mentally Retarded.

Another approach would be to introduce legislation that falls into one of the categories discussed above. Given the assertion among many of those interviewed that the Georgia Constitution would preclude any sweeping pre-emption of local zoning authority, a statute that fell into category 1 above would probably not survive a state Supreme Court challenge. However, a statute that makes it clear that small groups of mentally retarded persons (e.g., six or fewer) have a right to live in residential zones which also preserves the power of the local jurisdiction to impose some restrictions may be acceptable.

In any event, if the closure of GRC and Bainbridge goes forward, it will be imperative that a statewide zoning strategy be developed to ensure the expeditious expansion of community residential as well as day services.

E. Medical Back-Up Services

There is no single medical services arrangement that can or should be imposed across the state. Personnel in each service area must develop their own approach depending upon the character of their target population and the medical resources available.

There are, however, two core elements that should be present in each area:

- There must be an identified primary health care provider who assumes responsibility for the general medical care of each individual and makes referrals to specialists as needed. In the absence of a responsible family physician, a nurse practitioner should be employed (directly or under contract) to obtain the services of primary health care providers for individuals and to facilitate, organize and manage any individual interventions not managed through primary health care providers. The nurse practitioners should be a part of the IHP teams, and the family physician should be consulted by the IHP teams as part of the case management process. In some areas, teams of physicians, nurses and specialists may be organized as medical backup teams to provide service on an as-needed basis. Formal agreements or even contracts should also be negotiated with local hospitals providing for client care in the case of an emergency.

- There must be an array of specialty and consultation services capable of meeting the special and complex medical needs of persons with mental retardation and other developmental disabilities who are medically involved. Although it was beyond the scope of the study to assess fully, there are certain to be a number of clinical centers capable of developing an expertise in caring for persons with mental retardation and other developmental disabilities.

  If there is no clinical center in a particular service area, it may be necessary for the state to develop one. Such a unit could have many functions including: (1) coordination and referral for persons with complex needs, (2) provision of training programs for primary physicians, nurses, therapists and care giving personnel, (3) the provision of practicum placements for young professionals in the medicine and rehabilitation therapies.

The Steering Committee members participating in the site visit to Nebraska, for instance, found just such a medical support unit in Omaha located at one of the area hospitals. The unit, which is used in lieu of inpatient hospitalization, employs three full-time and three part-time registered nurses under the direction of a registered nurse supervisor, and three full-time and three part-time residential assistants. The projected costs of such a unit are included in Section III.

F. Crisis Support Services

One area of significant concern among the providers in the community is the absence of crisis support services. Crisis support services will have to be developed and made available to members of the target populations and other populations of concern.

Crisis support services are designed to help manage situational crises of persons living in the community. These services should have the capacity to respond to crises through visits to clients' homes, meetings with clients (and /or family members), consultation with residential and day staff, and outpatient counselling. Crisis staff efforts would be directed toward resolving the problem and maintaining the client in his/her "home" environment whenever possible.

Temporary crisis residential services may be provided in family personal care homes as is done in Colorado. Under this program, specially trained families are available on a retainer basis; each has the capacity to serve two clients.

Clients who cannot be accommodated in the family care setting could be accommodated in a group respite setting designed to serve individuals with overriding behavioral problems.

Again, members of the Steering Committee visiting Nebraska saw such a respite home in operation. The program, which is part of the medical back-up unit mentioned above, accommodates up to five clients. There are three full-time and three part-time residential staff under the supervision of the group home manager. Behavioral specialists and psychologists serve on staff and are also available as consultants. Backup psychiatric services are provided under an arrangement with a university hospital. Section III includes a projected budget for such a program in Georgia.

G. Interagency Collaboration

There are several interagency collaborative agreements that will be necessitated by an expedited expansion of community-based services for individuals with more severe disabilities. A range of state agencies both within the Department of Human Resources and in other departments should be included.

1. Department of Education

The data on the target population indicates a substantial number of individuals of school age. In order to accommodate their needs in the community, joint planning will be required between the Division and the Department of Education. Issues to be addressed include the preparation of local special education teachers for the transition, the development of justifications to extend educational services to age 21, and the provision of early intervention services to children under 3 years currently residing at GRC.

2. Department of Medical Assistance

If the proposals included in the Feasibility Study are adopted, successful collaboration with the Department of Medical Assistance will be crucial. First, the Division will need to work closely with the Department to develop a Title XIX waiver based on the capitation scheme outlined in Section IV. Second, in order to implement a capitation waiver mechanism, the Department of Medical Assistance will need to modify some of the current reimbursement and reporting procedures.

Finally, the Department of Medical Assistance should be involved in discussions concerning the outplacement of the technology dependent children currently at GRC and in the development of alternative placement strategies for those chronically ill children who will need such care in the future. The use of the Model 50 Medicaid waiver program (formerly Katie Beckett) should be explored and participation of the Title V agency (noted below) should be examined.

3. State Health Planning and Development Agency (SHPDA)

Given that the SHPDA is currently in the process of finalizing a plan for the future development of personal care homes in the state, the Division needs to collaborate closely with this body in order to ensure that the needs as outlined in the Feasibility Study are addressed.

4. Office of Regulatory Services

The development of modifications to the personal care home standards will require close collaboration with the Office of Regulatory Services. These changes include an upper limit on the number of beds, the development of additional categories, and minimum operation requirements. The agencies should also address expanded ORS staff and a division of responsibility for minimum versus programmatic standards.

5. Title V Program

There are currently a small number of technology dependent infants and young children in the skilled nursing portion of GRC. In order to find alternative placements for these children and to plan for the future care of other chronically ill children, the Division should enter into discussions with the state office responsible for administering the federal Title V program. The discussions should include what would be required to support home care for those children whose families are willing to provide such care and an alternative residential care setting for children whose families are not capable of providing care. The Department of Medical Assistance should be part of these discussions.

II. WHERE WILL THE STAFF COME FROM?

Essential to any community based system is the successful recruitment and retention of program staff. Moreover, the efforts of these staff must be complemented by professional staff who provide specialized services as needed. Thus, the phase-out of Georgia Retardation Center and the Southwest Developmental Center at Bainbridge in favor of community based services must be considered in light of the availability of sufficient staff. What follows is an examination of this issue with regard to: 1) direct care staff, 2) supervisory staff, 3) rehabilitation professionals, and 4) medical/health professionals. Additional long term policy issues are also discussed.

A. Acquiring Needed Staff

1. Direct Care Staff

The success of any service system for persons with mental retardation or other developmental disabilities is dependent on its capacity to provide quality care within least restrictive settings. In this regard, the presence of competent ***direct care staff*** is crucial. These staff are primarily responsible for the day-to-day or "hands on" care. They are charged with promoting client skill acquisition and maximum community integration, while fostering a safe and nurturing environment. Systems that retain competent direct care staff generally operate more efficiently and experience fewer crises than those whose staff turnover rapidly or are unprepared.

As revealed by Figure 43 on staff projections (See Part I; Section VI;C), project staff estimate that if present residents of GRC and Bainbridge are placed into community settings, a total of 1,008 direct care staff will be required, 707 staff to accommodate GRC residents, and 301 staff to serve Bainbridge residents. Acquiring these staff may present a significant challenge in the northern areas around Atlanta, owing to the economic boom the region is presently experiencing. Aside from Fulton County, the unemployment rates in the area are generally among the lowest in the state (See Figure 45 of Part I). Such economic growth, while beneficial to the area as a whole, can inhibit the recruitment of new staff due to the heightened competition among all industries for available labor. In contrast, it may be easier to recruit new direct care staff in the southern areas around Bainbridge because such economic growth is not as strong, as reflected by higher unemployment rates, and the competition for labor may not be as keen.

Regardless, direct care staff can be found to accommodate both GRC and SDC residents if the following strategies are pursued in tandem:

a. Make the greatest use of present institution staff.

As noted in Figure 43 (Part One), GRC presently employs 578 direct care staff, while Bainbridge employs 232 such staff -- resulting in staff to client ratios that are among the richest in the country for institutional facilities. Obviously, if a large number of these staff agree to work within new community settings, their presence would reduce the need for additional new staff, an outcome that would ease the transition process.

The number of present institutional staff who actually will agree to work within the community is unknown, though the experiences of other states and anecdotal data collected in Georgia suggest that a significant number will. This, however, is contingent on the extent to which any new private providers are able to approximate the benefits being received by such staff. To encourage high rates of transition from GRC or Bainbridge to community work, state officials should take into account these two factors:

- ***Compensation.*** The compensation these staff will receive as employees within a community agency, public or private, will be an important consideration. Staff will want to be assured that they will not incur a significant cut in pay or benefits to obtain work in the community.

- ***Maintaining present staff/client relationships.*** It is fair to assume that many staff have developed close relationships with the persons for whom they are responsible. To ease the transition, from both the staff's and client's perspective, it may prove beneficial to assure staff that they will continue to work with their present clients whenever feasible and desirable.

In addition, the state may consider an approach, used in Colorado and elsewhere, where institution direct care staff are encouraged to and supported in offering family care arrangements to persons placed out of GRC or Bainbridge. This approach has several advantages, including the maintenance of existing staff/resident relationships, providing an alternative means of employment for staff whose jobs may be otherwise threatened, and avoiding the start-up and capital costs related to other residential alternatives. In the same way, staff from GRC and Bainbridge could be assisted with establishing service organizations that could serve GRC and Bainbridge clients once placed in the community.

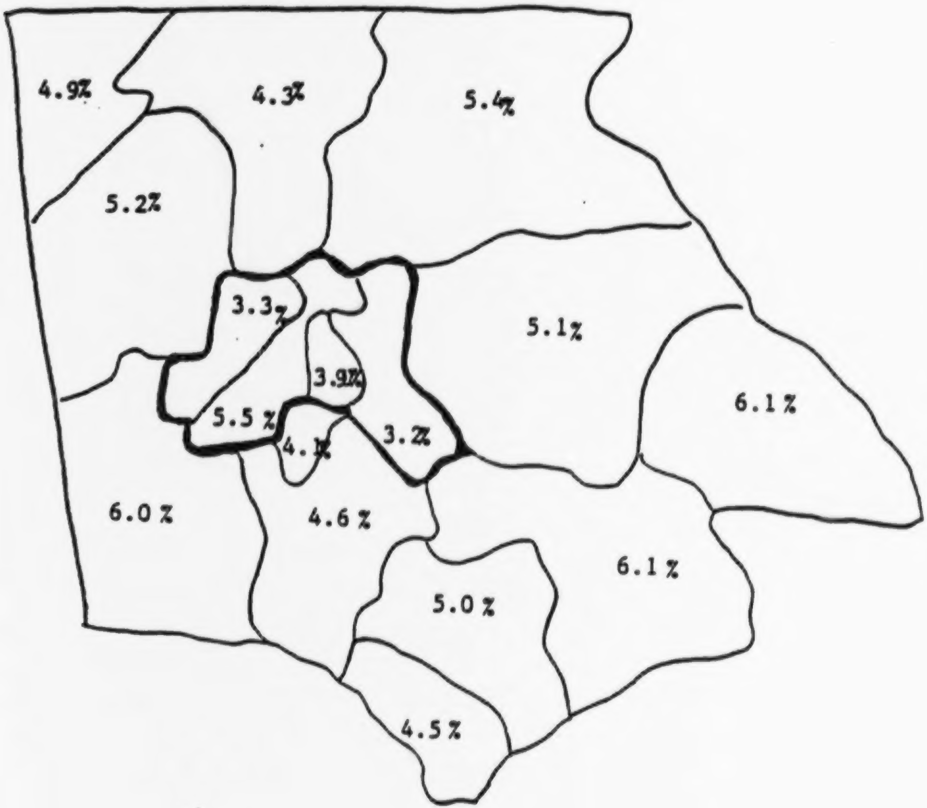
b. Widen the strategies used to recruit direct care staff.

Results of the community provider survey (See Part I; Section II:E) reveal that to acquire new direct care staff, agency administrators primarily rely upon newspaper ads or word-of-mouth. On average, as shown by Figures 26 and 27 in Part One, the time typically needed to find day program staff is four to six weeks, while the time needed to find residential staff averages around two to four weeks. If other means of recruitment were used systematically, however, the time needed to find new staff may be reduced. Certainly, with the establishment of new programs, the utility of previous recruitment methods will be tested and alternative means for identifying new staff may need to be found.

Other recruitment strategies that may be explored and systematically applied include: 1) contacting private or public employment agencies, 2) contacting high school or college placement offices, including vocational education centers, 3) contacting professional organizations, 4) contacting various human services training programs, and 5) recruiting staff from other states. In each instance the utility of a given recruitment strategy will be enhanced if it is applied systematically. For instance, it is not enough to contact a placement office once without follow-up. Instead, a collaborative relationship between multiple service agencies and placement offices should be built for the long term, providing human service agencies with a steady flow of applicants from which to choose. Subsequently, the effectiveness of various recruitment strategies should be assessed to shape future recruitment activities.

Additionally, service agencies in the northern areas should consider actively recruiting staff from the areas surrounding Atlanta. Figure 1 below shows the unemployment rates in MH/MR/SA service areas within and surrounding the Atlanta area. As shown, the unemployment rates in the surrounding areas are somewhat higher than those in the Atlanta area, suggesting that, on average, it may be easier to recruit new staff in these other areas. Prospective staff looking for work in these areas may be willing to commute to the Atlanta area or re-locate altogether.

FIGURE 1: RELATIVE UNEMPLOYMENT RATES IN NORTHERN AREAS



c. Consider alternative service delivery models.

The selection of certain habilitative models over others carries implications regarding the working conditions under which staff are expected to perform. For instance, adopting a supported work model where certain job sites require the client to work at odd hours will require staff who are willing to provide needed assistance during those same odd hours. Similarly, if a residential model is chosen in which staff must "live in" the residence and function as "house parents," staff willing to serve in this capacity will be needed. In either case, the selection of a particular service model places limits on the labor that can be successfully recruited. In some instances, the perception that labor resources are insufficient may be related to the presence of

habilitative models which entail unconventional and sometimes unattractive working conditions. If such models were changed to alter the working conditions, additional sources of labor could be tapped, and potential recruitment difficulties eased.

One particular issue the state may wish to consider carefully pertains to the staffing of community residences. Models whereby persons must "live-in" the residence with periodic time off are popular in Georgia. Though this model carries certain advantages, given the continuity such staff can provide, it severely restricts the type of labor that can be recruited. For example, people with families may be discouraged from assuming full time residential duties, given that they would need to move their entire family into the residence or maintain a separate residence for their family. Likewise, young workers may shy away from or be unprepared for the level of commitment this model requires.

Given a potential shortage of labor, especially in the Atlanta area, it would seem prudent to develop residential models that are attractive as work sites to the most people possible. Thus, instead of a "live-in" residential model, a "shift" model may be preferred where no staff need live-in in most instances, the residence. Though overnight coverage would still be required, in most instances, viewed as a shift, overnight stays will seem tolerable to a sufficient number of persons.

d. Utilize resources available through the Job Training and Partnership Act

The Job Training Partnership Act (JTPA) is a federal program which provides monies for training persons with histories of under or unemployment so that they can effectively compete for and retain job opportunities. Historically, many recipients of JTPA funds are female welfare recipients, usually with dependents, having little or no secondary education. JTPA funds are administered through local Private Industry Councils (PIC). These councils administer job training programs, screen and select applicants for the training, and submit proposals to the state JTPA office for funding of particular training programs.

JTPA resources can provide a significant resource for recruiting direct care staff. The training programs offered could provide trainees with knowledge and skills that most typical newly recruited staff do not possess. Several representatives of local PIC councils were contacted in the course of this study, with all indicating a willingness to consider using JTPA funds to train and prepare a substantial number of direct care staff for community positions.

From the JTPA perspective, however, there are certain drawbacks to their endorsement of a proposal for a training program for community staff. In general, JTPA prefers to train persons for positions that offer substantial growth and promotional opportunities. This is unfortunately not the case with most community direct care positions. Nonetheless, the starting pay of public community-based positions is within the parameters set by JTPA, standards, and the public merit system offers regular salary advancements and a relatively secure position. For some JTPA applicants, therefore, obtaining a community direct-care position is a reasonable vocational objective.

State administrators are well advised to consider approaching local PIC's in the Atlanta area to form a long range plan for preparing direct care staff. If some councils are unenthusiastic about proposing funding for this training, state planners could provide the actual training monies, and the council can provide a list of applicants or training resources. Another option that JTPA offers is "retraining funds." These monies could perhaps be utilized to "retrain" institutional staff for community-based positions.

2. Supervisory Staff

Depending on the habilitative models chosen, a number of supervisory staff will be required to oversee the provision of direct care services. These persons are key to the success of the community system, yet results generated by the community provider survey (See Part I; Section II;E) suggest that such persons are in short supply. Typically, given a vacant supervisory position, it takes at least a month, and often longer, to fill the position (See Figure 26 in Part I).

To assure that sufficient numbers of supervisory staff are available to support the phase-out of GRC and Bainbridge, numerous strategies must be pursued, including:

- ***Utilization of institutional staff.*** This strategy was noted above with reference to direct care staff. Supervisors at GRC and Bainbridge can be retrained as warranted and placed in charge of appropriate community programs. However, many of the considerations noted above pertaining to the number of present GRC/Bainbridge direct care staff who would be willing to transfer to community programs apply to supervisory staff as well.

- ***Promote existing community staff.*** Some number of current community direct care staff likely possess those skills needed to serve as program supervisors. Such persons may not advance within their current agencies because of limits to the number of supervisory positions available. The development of additional community programs, however, could provide these persons with a new career opportunity.

- ***Actively recruit staff from other states.*** During times of quickened systems change, it is not unusual for states to recruit skilled personnel from other states. Several states have vigorously pursued development of community programs, resulting in a pool of skilled labor that can be tapped in conjunction with the phase-out of GRC and Bainbridge. The state may consider recruiting such persons in a systematic fashion by advertising in professional journals or selected newspapers, contacting relevant universities, or presenting information on available employment at professional conferences.

- ***Coordinate with Georgia's centers of higher education.*** The qualifications usually required of supervisory staff typically include some level of competence or experience with providing services to persons with developmental disabilities and/or a college degree. At present, there are several college programs which could serve as a resource for obtaining qualified persons for anticipated community-based supervisory positions. For instance, the Georgia Post-secondary School Directory (1987) lists three colleges that offer Associates and/or Bachelor's degrees in Human Services (Atlanta Junior, Georgia Southwestern, and Tift colleges). Two other colleges offer degrees in mental health: Georgia State and Floyd Junior Colleges. Discussions with department chairs from certain of these programs reveals the following:

  -- Many students in their programs were previously employed by the institution system and are interested in continuing their work with persons with developmental disabilities after graduation;

  -- Many faculty (especially at Atlanta Junior college) have substantial experience and expertise in developmental disabilities;

  -- Given sufficient student demand or a request from state administrators, a specialization in developmental disabilities could be generated in some programs and would be encouraged and welcome.

In light of these considerations, collaboration with Georgia colleges to prepare a labor pool of supervisory staff seems warranted, if not overdue. College personnel would be especially willing to collaborate with the state in such a venture, if the state would tie scholarships or tuition remission monies to the educational programs. In return, students benefiting from such programs could serve in community-based positions for a given length of time, either while attending school or after.

Even without attached monies, the colleges appear interested in helping with the preparation of supervisory staff. An active recruitment program (i.e., presentations at a career day or job fair) in tandem with collaboration from college administrators seems to be a viable and effective strategy for recruiting supervisory staff.

3. Specialized Habilitative Staff

Persons with mental retardation or other developmental disabilities may have conditions that require services from specialized professionals, such as physical therapists, speech/hearing therapists, occupational therapists, behavior specialists and psychologists. Figure 41 (See Part I) displays the number of specialized professionals by discipline that will be required in the community, and the number of these positions currently held at GRC and Bainbridge. Review of this figure suggests that if the specialized staff currently employed at GRC and Bainbridge agree to continue their work within community settings, the needs of GRC and Bainbridge residents will be almost fully satisfied.

In any event, to assure that sufficient numbers of specialized professionals are available for the long term, the state should take the following considerations into account:

- With the exception of psychologists and behavioral specialists, it should be understood that physical, occupational and speech/hearing therapists are not plentiful anywhere. Shortages of these professionals, and especially physical therapists, are felt throughout the country. Institutions find it nearly impossible to recruit these individuals successfully as institutions are increasingly seen as professionally isolating. One position at Bainbridge for a physical therapist has remained vacant for some time now, despite systematic efforts to recruit a qualified therapist. Given that a shortage of qualified therapists seems chronic and without easy solution, the state should take steps to promote development of and collaboration with professional training programs in Georgia to generate a local supply of trained therapists. Efforts at Valdosta State College to initiate a training program for occupational and physical therapists should receive the continued support of state officials.

- Administrators should also consider access to consulting therapists and specialized professionals already in the community in the course of identifying residential program sites for individuals in need of these services. In this way, providers can take advantage of a larger cadre of specialists. Additionally, the state should encourage the development of an entrepreneurial model of contracted services regarding specialized professionals, at least one such model currently exists in Atlanta. In such a model, specialized professionals band together as a practice and provide services to individuals on a fee basis. Such an arrangement may be attractive to current professional staff at GRC or Bainbridge.

4. Medical Services

Present GRC and Bainbridge residents will also require health related services once placed into the community. In addition to routine health care, many will require ongoing review of their health status, while some will require intensive care.

For many clients, health care services already available in the community will suffice. The services of GRC and Bainbridge medical staff, however, will also be needed to accommodate the needs of those with overriding and some chronic medical complications. In view of the health status of institution residents as assessed by ICAP (See Part One; Section III), this issue will have greater import for GRC residents than for those at Bainbridge. Owing to the significant number of persons at GRC with medical complications, every effort must be made to assure that those nurses presently working with the persons will follow them into the community.

Present GRC and Bainbridge medical staff may be utilized in other ways as well. As noted previously (See Part II; Section II; G), these professionals may also be employed in medical back-up units and to coordinate other client health care services on behalf of other clients.

B. Additional Considerations

When considering the availability of staff to support the phase-out of GRC or Bainbridge, two additional factors must be taken into account: 1) the need to nurture development of a ***community based human services industry*** across Georgia to which prospective staff will be drawn, and 2) the need to develop of an ***exemplary staff development system*** to assure the competence of program staff.

1. Development of a Community Based Human Services Industry

Assuring the availability of competent community staff across Georgia, and in particular to support the phase-out of GRC and Bainbridge, may prove difficult at first. Respondents to the community provider survey indicated that an absence of needed labor could act as a significant deterrent to program expansion.

These conditions, however, need not be permanent. As the community system is expanded, steps must be taken to build collaborative relationships with the state's centers of secondary and higher education. These centers could be utilized to build a pool of available and competent labor that could eventually be used to staff programs across the state. When developing such relationships, the state must take a hard look at its salary structures so that they will be attractive to students.

Likewise, providers across the state can do more to coordinate their efforts and make the most of available resources. As community providers move to serve persons with severe disabilities, each may benefit greatly from the resources, skills and experiences commanded by others. To the extent providers learn to collaborate on service related issues, the service capacity of individual providers will be enhanced.

2. Staff Development

Regardless of habilitative setting, the presence of competent staff can have a positive effect on client development and life style, overall system efficiency, and public opinion. Respondents to the community provider survey indicated that new staff typically had no or little experience with disabilities (See Figures 29 and 30 in Part One). In accordance with this finding, respondents also revealed a great need for additional staff training on a great range of topics (See Figure 32 in Part One). Yet the majority of respondents noted that they provide only six days or less of formalized training to direct care staff (See Figure 31 in Part One). Given the importance of well prepared staff, these findings are cause for concern, especially in light of needs of GRC and Bainbridge residents.

To assure the success of these persons once placed into the community, the state must take steps to develop and implement plans for training community staff. At the least, this should involve instruction for new community staff and those institutional staff transferring to community programs. It must be understood that ***the skills needed for***

working in an institution are not identical to those needed for community work. This holds true for staff at all levels, including supervisors and habilitative specialists such as behavioral technicians. Great care should be taken to orient institution staff to community work and to provide additional instruction as needed.

Simply providing a staff development program for persons serving GRC and Bainbridge clients, however, is insufficient for the long term. In the interest of developing a human services industry in Georgia and an exemplary system of services statewide, the state should act to establish a formalized staff training program on behalf of all clients. Seven key characteristics of such a model were presented earlier (See Part I; Section VI;F) and include: 1) leadership, 2) integration of state-of-the-art best practice into the instructional content, 3) use of existing resources and experience, 4) flexibility, 5) incentives, 6) use of indigenous training resources, and 7) utilization of a range of funding mechanisms.

Further, in Appendix G, a prototype of a statewide staff training model presently under consideration in Iowa is displayed. The model is based on a review of best practice staff training programs in operation around the country and reflects the preferences of those in Iowa. Though decision makers in Georgia must reach their own conclusions regarding the essential elements of a staff development program, the Iowa model is instructive because it brings to light many of the crucial issues that must be addressed, including these five:

- ***development of consensus.*** Within any system there is divergent opinion regarding the best means to approach habilitation and needed staff development. Yet to enhance the effectiveness of the staff development system, means must be found to reach consensus involving all concerned parties, including consumers, providers and state officials, over the best means to proceed.

- ***Content and sequence of instruction.*** What will be taught to staff and in what order? Discussion will be needed regarding what skills staff most need and in what sequence they should be taught;

- ***Source of instruction.*** How will provide staff with needed instructions? Numerous options exist. Personnel employed at the state's centers of higher education could provide certain types of training. Training specialists, acting either as state employees or private consultants, could serve as "regional trainers," accommodating multiple agencies at once. Staff of existing agencies could act as "proctors," training other agency staff. Finally, self teaching materials could be utilized to diminish the need for "live" instructors.

- ***Accountability and certification.*** Should the staff training program be so standardized in its content and sequence that staff could be tested and "certified" to document some level of expertise? To the extent staff standards are implemented, services across the state will become increasingly comparable and staff who move between programs may be judged by their new employees more easily. Yet some may balk at the potential loss of control over what staff training activities are deemed appropriate and at a statewide standardized system in general. A similar issue must be faced with regard to those who provide the training. Means for documenting their competence may also be needed.

- ***Agency autonomy.*** Given a statewide staff training initiative, should all service providers be required to participate in the program? Some believe that a statewide staff training program must be a made mandatory, with all service agencies participating. Full participation can help to assure that accepted habilitative practice is followed across the state. In contrast, others hold that providers should participate only voluntarily.

III. WHAT SERVICES WILL BE REQUIRED TO MEET THE NEEDS OF PERSONS IN THE TARGET POPULATIONS AND OTHER POPULATIONS OF CONCERN AND WHAT WILL THEY COST?

This section first describes the current target populations and other populations of concern by age and level of functioning, and projects the size of these subpopulations in 1992 (Subsection A). The projections include persons awaiting service in those seven MH/MR/SA services areas identified as home to the largest numbers of GRC and Bainbridge residents. These persons were included -- as discussed in Part One -- in the event that policy makers decide to provide services to these individuals as well as to members of the GRC and Bainbridge target populations in the interest of equity and to address the needs of individuals in the community.

Subsection B then projects the ongoing services required to provide these individuals with a level of care at least equal to and in many ways exceeding the level of care being received at GRC and Bainbridge. It also includes the projected costs of these services.

It is important to note that while these projections are reasonable for the purposes of this study, they are still based on estimates. In order to assure that these projections do not understate the services found to be needed during the IHP processes, HSRI has, whenever in doubt, employed the higher service utilization estimates.

Subsection C includes projections of the one-time costs associated with the start-up of community-based services. The start-up costs are gleaned from experiences in other states as reported to HSRI in a multi-state survey of service start-up costs. The bases for the cost estimates are explained and start-up budgets are presented for different types of residential, day and support services.

A. Projected Demand

1. Base Data and Assumptions

In order to project change in service demand expected over the next four years (through 1992) within the limited time and resources available for this study, HSRI focused on the seven MH/MR/SA service areas housing the largest number of GRC/Bainbridge residents (see Part

One, Section II for the selection rationale). Fortunately, the Division of MH/MR/SA has regularly compiled lists of persons awaiting day services, and expedited HSRI's request for a special survey of persons awaiting residential services. Together with the Department's management information system data on the number of persons in institutions and community-based services in these areas from 1984 to date, and a 1984 study of persons awaiting residential services undertaken for the Developmental Disabilities Planning Council, HSRI attempted to identify trends in the magnitude of the expressed demand for services (including those in and awaiting service).

However, no trends could be discerned upon which to anchor the demand projections. Nonetheless these data were sufficient to at least identify the age and the approximate level of functioning of those individuals awaiting residential and day services. The residential and day census data could also be broken out by age and level of functioning based on a sample of 648 clients in the metropolitan Atlanta service areas and in the southwest Georgia service areas. Thus, the projections are generally sensitive to age and level-of-functioning.

For the purposes of this study, the projections of demand through 1992 assume that the current number of persons in each age and planning group (level of functioning) demanding service relative to the number of persons in that age group within the general population will hold constant (i.e., that any changes in demand will result from changes in size of the general population).

Expected changes in the level of client functioning over time and associated changes in the patterns of service demand are not factored into these projections.

These projections could be skewed to some extent by the fact that they do not include persons who are being served in other areas of the state and outside of the GRC and Bainbridge facilities. These projections focus only on four MH/MR service areas around metropolitan Atlanta (Fulton, DeKalb, Cobb-Douglas, and Gwinnette) and three service areas in southwest Georgia (Thomas, Dougherty and Lowndes).

2. Projections

Figure 2 shows the *current* distribution of the study subpopulations by age and planning group. Figure 3 shows the *projected* distribution of the study subpopulations by age and planning group. Service requirements and costs are projected for all of these subpopulations except one, those individuals already participating in community-based services.

FIGURE 2: STUDY SUBPOPULATIONS BY AGE AND LEVEL-OF-FUNCTIONING - 1987

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> 1 SKL IV OVRDG MED/PHYS	2 SKL IV OVRDG BEHVR	3 SKL IV CHRONIC & OTHER	4 SKL III OVRDG BEHVR	5 SKL III CHRONIC	6 SKL III OTHER	7 SKL II OVRDG BEHVR	8 SKL II CHRONIC	9 SKL II OTHER	10 SKL I OTHER
GRC RES & VTG/ALL	439	97	10	253	3	38	28	2	2	6	0
BSH RES/ALL	196	4	17	133	1	21	11	1	4	4	0
ATL COMM IN-SVC/ALL	1,581	73	38	543	4	120	255	0	85	325	139
SW COMM IN-SVC/ALL	1,275	17	21	270	13	160	300	5	36	253	201
ATL COMM VTG/ALL	376	24	4	27	12	85	49	8	93	68	6
SW COMM VTG/ALL	221	13	10	19	17	42	25	15	32	46	0

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL II CHRONIC	SKL II OTHER	SKL I OTHER
GRC RES & VTG/0-5	12	7	0	5	0	0	0	0	0	0	0
BSH RES/0-5	0	0	0	0	0	0	0	0	0	0	0
ATL COMM IN-SVC/0-5	332	34	11	275	0	0	11	0	0	0	0
SW COMM IN-SVC/0-5	139	5	0	108	0	0	26	0	0	0	0
ATL COMM VTG/0-5	49	6	0	0	3	17	5	0	10	8	0
SW COMM VTG/0-5	11	3	0	2	0	0	2	0	2	2	0

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL II CHRONIC	SKL II OTHER	SKL I OTHER
GRC RES & VTG/6-21	127	34	2	77	1	10	1	1	0	1	0
BSH RES/6-21	43	1	3	28	0	4	5	0	2	0	0
ATL COMM IN-SVC/6-21	119	24	0	48	0	8	16	0	0	16	8
SW COMM IN-SVC/6-21	176	0	9	37	5	23	32	5	5	23	37
ATL COMM VTG/6-21	40	3	1	0	3	14	2	3	9	4	1
SW COMM VTG/6-21	65	7	7	2	7	14	5	6	6	11	0

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL II CHRONIC	SKL II OTHER	SKL I OTHER
GRC RES & VTG/22+	300	56	8	171	2	28	27	1	2	5	0
BSH RES/22+	153	3	14	105	1	17	6	1	2	4	0
ATL COMM IN-SVC/22+	1,130	15	27	220	4	112	228	0	85	309	131
SW COMM IN-SVC/22+	960	12	12	125	8	137	242	0	31	230	164
ATL COMM VTG/22+	287	15	3	27	6	54	42	5	74	56	5
SW COMM VTG/22+	145	3	3	15	10	28	18	9	24	33	0

FIGURE 3: STUDY SUBPOPULATIONS BY AGE AND LEVEL-OF-FUNCTIONING - 1992

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> 1 SKL IV OVRDG MED/PHYS	2 SKL IV OVRDG BEHVR	3 SKL IV CHRONIC & OTHER	4 SKL III OVRDG BEHVR	5 SKL III CHRONIC	6 SKL III OTHER	7 SKL II OVRDG BEHVR	8 SKL II CHRONIC	9 SKL II OTHER	10 SKL I OTHER
GRC RES & VTG/ALL	485	107	11	280	3	42	31	2	2	7	0
BGH RES/ALL	210	4	18	142	1	22	12	1	4	4	0
ATL COMM IN-SVC/ALL	1,743	80	42	597	4	133	282	0	94	360	154
SW COMM IN-SVC/ALL	1,364	18	22	287	14	171	321	5	39	271	213
ATL COMM VTG/ALL	415	26	4	30	13	94	54	9	103	73	7
SW COMM VTG/ALL	236	16	11	20	18	45	27	16	34	49	0

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL II CHRONIC	SKL II OTHER	SKL I OTHER
GRC RES & VTG/0-5	13	8	0	5	0	0	0	0	0	0	0
BGH RES/0-5	0	0	0	0	0	0	0	0	0	0	0
ATL COMM IN-SVC/0-5	361	37	12	300	0	0	12	0	0	0	0
SW COMM IN-SVC/0-5	146	5	0	113	0	0	27	0	0	0	0
ATL COMM VTG/0-5	53	7	0	0	3	19	5	0	11	9	0
SW COMM VTG/0-5	12	3	0	2	0	0	2	0	2	2	0

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL II CHRONIC	SKL II OTHER	SKL I OTHER
GRC RES & VTG/6-21	140	37	2	85	1	11	1	1	0	1	0
BGH RES/6-21	46	1	3	30	0	4	5	0	2	0	0
ATL COMM IN-SVC/6-21	132	26	0	53	0	9	18	0	0	18	9
SW COMM IN-SVC/6-21	186	0	10	39	5	24	34	5	5	24	39
ATL COMM VTG/6-21	44	3	1	0	3	15	2	3	10	4	1
SW COMM VTG/6-21	69	7	7	2	7	13	5	6	6	12	0

SUBPOPULATION/AGE:	TOTAL ALL L-O-F	L-O-F -> SKL IV OVRDG MED/PHYS	SKL IV OVRDG BEHVR	SKL IV CHRONIC & OTHER	SKL III OVRDG BEHVR	SKL III CHRONIC	SKL III OTHER	SKL II OVRDG BEHVR	SKL II CHRONIC	SKL II OTHER	SKL I OTHER
GRC RES & VTG/22+	332	62	9	189	2	31	30	1	2	6	0
BGH RES/22+	164	3	13	113	1	18	6	1	2	4	0
ATL COMM IN-SVC/22+	1,251	17	30	243	4	124	252	0	94	342	145
SW COMM IN-SVC/22+	1,032	13	13	134	9	147	260	0	33	247	176
ATL COMM VTG/22+	318	17	3	30	7	60	46	6	82	62	6
SW COMM VTG/22+	156	5	3	16	11	30	19	10	26	33	0

B. Projected Annual Service Requirements and Costs

In this section, the assumptions and empirical bases for the service utilization and unit cost figures employed in making these projections are defined. The discussion is organized by categories and types of service. The projections are then presented. The assignment of individuals and the development of the service array was premised on the following principles:

> **Normalization** -- Normalization is rooted in the belief that persons with disabilities are stigmatized because they are forced to reside in structures that -- due to their size, design, and location -- reinforce the separateness and isolation of those who live there. It is also premised on the notion that such stigma prevents a personal growth and inhibits meaningful social interaction
>
> **Right to reside in the least restrictive environment** -- To the extent of their capabilities all developmentally disabled persons who have not committed a crime or proved themselves to be a danger to society have a right to be free of personal and physical restrictions. This right has been recognized in recent court decisions regarding the constitutional rights of persons with developmental disabilities residing in institutions.
>
> **Right to treatment** -- If an instrumentality of the government deprives a person of his or her liberty so as to provide care and habilitation, then it must provide care based on generally accepted standards. This value derives specifically from a constitutional argument that has been accepted in several judicial jurisdictions as a rationale for upgrading the level of institutional care for persons held involuntarily.
>
> **Protection from harm** -- Protection from harm is a value that has a basis in societal norms and that additionally has been recognized through litigation as being applicable to the rights of developmentally disabled persons in institutions. In this context, it means that persons responsible for caring for the developmentally disabled are responsible for the continued physical and emotional well-being of those in their charge.

1. Base Data

The base data used in making these projections includes the percent of clients utilizing services, the level of service utilization, and the service unit costs by type of service and client level of functioning (planning group). These projections assume that the state will, as recommended in Section IV develop small ICF-MRs to serve those individuals with overriding, physical and behavioral problems (planning groups 1 and 2), and will apply for Title XIX waiver funds to provide services to the other members of the GRC, Bainbridge and community waiting list populations.

The sources of these data and other basic assumptions are discussed below. The discussion is organized by service type.

a. Case Management and Cluster Management

1) Case Management

The management of client services is by definition an individualized process varying considerably in character and intensity from client to client and situation to situation. As such, it defies attempts to arrive at average levels of effort that should be expended per case. For instance, much more time is demanded by clients who are in the process of changing residential or day programs than by clients who are making no such changes. This caveat notwithstanding, most responsibilities can be generally agreed upon as part of the case manager's job. These responsibilities are noted below.

a) Intake

- Complete the initial interviews with the client and his or her family to assess the client's eligibility for services;
- Gather relevant and useful data from the client, family, other agencies, and so on to formulate a psychosocial assessment of the client and his or her family;

b) Service Coordination

- Assemble and guide group discussions and decision-making sessions among relevant professionals, program representatives, the client and his or her family, and significant others to formulate goals and design an integrated intervention plan;

- Monitor adherence to the plan and manage the flow of accurate information within the system to maintain the focus on goals and to maintain momentum;

- Complete the necessary paperwork to maintain documentation of client progress and adherence to the plan by all concerned.

c) Liaison and Advocacy

- Provide counselling and information to help the client and his or her family in situations of crisis and conflict with service providers;

- Provide ongoing emotional support to help the client and his or her family so they can cope better with problems and better utilize professionals and complex services;

- Provide "follow-along" to the client and his or her family to speed identification of unexpected problems in service delivery;

- Act as a liaison between the client and his or her family to serve as a general troubleshooter on behalf of the client;

- Act as a liaison among programs providing service to the client to ensure the smooth flow of information and minimize conflict between the subsystems;

- Establish and maintain credibility and good public relations with significant formal and informal resource systems to mobilize resources for current and future clients;

- Secure and maintain the respect and support of those in positions of authority so their influence can be enlisted on behalf of the client and used, when necessary, to encourage other individuals and agencies to participate in the coordination effort.

Based on HSRI's own analyses of case management functions and costs in Pennsylvania, (Ashbaugh & Allard, 1984), and reviews of studies, analyses and standards in other states (Caragonne, P., undated), HSRI judges that caseloads approaching 50 allow caseworkers to perform little more than the basic intake functions and to participate in the preparation of individual habilitation plans -- a basic level of service. More moderate caseloads around 40 allow for intake, for the preparation of individual habilitation plans, as well as for some service coordination and monitoring to assure plan adherence -- a moderate level of service. Caseloads of 30 or less allow case managers to perform most of the liaison and advocacy functions as well -- an intense level of service. Assuming 1726 hours available annually per full time equivalent case manager, these caseloads translate into 34+ hours per client at the minimum or basic level, 40+ hours at the moderate level, and 58+ hours per client at the intense level.

The case management system formulated by the Division of Mental Health, Mental Retardation and Substance Abuse and recently incorporated into the state Medicaid plan provides for case management services at the *moderate* level, a level that is more than adequate considering the fact that cluster managers (recommended in Section I) will be complementing their efforts in developing and brokering services for clients. The unit cost figures employed in these projections are consistent with unit costs figures employed by the Division. It is assumed that these case managers will serve all members of the target population.

2) Cluster Management

Each cluster manager is projected to serve 20 individuals. The cluster manager's annual salary is projected to be $21,816 (pay grade 28, step 4). Fringe benefits would be 33.37% of salary plus $250.

b. Residential and Day Services

Seventy percent of the children ages 0-21 are projected to enter ICF-MRs and group homes, the remaining 30% are projected to reside with family/relatives or in family personal care homes (maximum two residents) with intensive support. Except for those higher functioning adults (planning groups 8 and above) projected to enter family care homes, nearly all are projected to enter small group homes.

Day programs and specialized services for programs in ICF-MR's are not identified separately and are included in the ICF-MR rate. A small percentage of adults in planning group 3 are projected to receive specialized services in lieu of day services.

ICF-MR, group home, and day program per diems are primarily a function of staff salaries and fringe benefits, the amount of staff time available to clients (staff intensity), and, in the case of residential services, the hours of staff coverage required (8, 16 or 24 hours a day). In the case of ICF-MRs and group homes, the number of residents served can also be a factor for smaller programs. For instance, it is assumed:

- that residential staff are allowed an average of 31 days of paid absences each year (three weeks vacation, 10 holidays, and six sick days) or an average of five hours per week; the work time available per staff member then is 35 hours per week;

- that clients participate in away-from-home day activities 30 hours per week leaving 138 hours (7 days X 24 hours - 30 hours) for residential supervision, and

- that staff shifts overlap by 30 minutes, effectively reducing the hours of alone-supervision provided by one-half hour per shift. Thus, in the case of a program requiring 24 hour coverage, the minimum number of staff hours required would be 138 hours + (one half hour X 3 shifts times 7 days) or 148.5 hours. The minimum staffing complement required would be 4.25 staff (148.5/35).

If a 24-hour program serves four residents, the minimum staff to client ratio would be a little over 1:1 with 37 (148.5/4) hours available for each resident. On the other hand, if a program serves eight residents, the minimum staff to client ratio could be reduced to .5:1, the equivalent of 18.5 hours per resident.

By this same logic, the minimum weekly staff hours per client in a program with 16 hours of coverage per day would be 86.5 hours of staff time per week or 2.5 staff.

The weekly hours of staff time projected per client reflect a moderate level of staff intensity, exceeding Title XIX ICF-MR standards, and ACMR-DD standards. Figure 4 shows the weekly hours of staff time projected to be available per client for ICF-MR, group home, and day programs.

Other assumptions employed in HSRI's projections of residential and day program per diem costs in Georgia are listed below:

- average non-supervisory residential worker staff salary of $15,924 (pay grade 20, step 4);
- average non-supervisory day service worker salary of $14,778 (pay grade 18, step 4);
- fringe benefits (excluding paid absences) of 33.37% plus $250;
- average ICF-MR capacity of six residents;
- average group facility capacity of four residents;
- average personal care home capacity of 1.5 residents;
- average apartment program capacity of six residents made up of separate two and three bedroom apartments;
- unpaid sleep-over staff for planning group eight;
- minimal supervision (no sleep over) for planning groups 9 and 10.

The formulas that HSRI uses to expand the weekly hours of staff time per client, salary level and fringe benefit rates, operating cost allowances and capacity into per diem costs are based on HSRI's analysis of the operating expenditures of several hundred residential and day programs in six states (Pennsylvania, Colorado, Virginia, Washington, Nebraska and Michigan) and Canada. The costs include client transportation, and in the case of ICF-MR's, nursing, clinical and therapeutic services. It is important to note that while these formulas generate reasonable cost estimates for purposes of strategic planning, subsequent cost estimates should be built upon model program budgets in order to capture other factors unique to Georgia that may not be reflected in the formulas, to support manpower planning activities more effectively, and to substantiate budget requests and resource allocation decisions with greater clarity.

The specialized family care services are family models serving one or two individuals. The per diem costs shown for lower-functioning individuals are higher then prevailing rates, but are commensurate with

HSRI's recommendations (Section I) to develop specialized family care models of service for these individuals.

Supported employment costs are estimated at 75% of sheltered work costs based on a study of supported employment program costs in the State of Virginia (Rehabilitation Research and Training Center, Virginia Commonwealth University, 1986). Pre-school per diems for higher-functioning children are based on Cobb County's recent budget request for an integrated pre-school program. Pre-school per diems for lower-functioning children are based on an analysis of pre-school program costs in Colorado, (Smith, 1986, unpublished).

The units of service for residential programs are shown as 365 days per client per year. The units of service for day programs are shown as 240 days per client per year.

FIGURE 4: WEEKLY HOURS OF STAFF TIME PER CLIENT BY TYPE OF PROGRAM AND PLANNING GROUP*

PLANNING GROUP:		PROGRAM TYPE NON-ICF-MR**	ICF-MR***	DAY
No.	Description			
1	MED/PHYS OVRDG SKL IV	60	60	12
2	BEH-OVRDG SKL IV	65	65	14
3	CHRONIC&OTHER SKL IV	45	45	11
4	BEH-OVRDG SKL III	65	65	13
5	CHRONIC SKL III	41	41	10
6	OTHER SKL III	36	36	9
7	BEH-OVRDG SKL III	55	55	11
8	CHRONIC SKL II	27	27	8
9	OTHER SKL II	13	27	7
10	OTHER SKL I	13	27	6

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* Includes hours of direct care staff (supervisory and non-supervisory) staff time spent with clients

** Average capacity of four residents

*** Average capacity of six residents

c. Home-Based Training, Respite Care, Home Health and Personal Care Services

All individuals projected to live independently or with relatives are expected to receive home health or personal care services, respite care and home based training. The utilization levels projected by planning group are based in large part on a draft schedule of service requirements prepared by the Division of Mental Health, and Mental Retardation and Substance Abuse, Mental Retardation Services Section. The service rates are consistent with the Title XIX rates set out in the Division's Medicaid Waiver application.

This combination of services is provided for the target population in lieu of the family support subsidy described next.

d. Family Education and Support

Annual family support costs are set at $5,000. This figure is consistent with the Wisconsin model of family support services as adapted by the Division for the family support pilot project in Georgia (Guidelines for the Family Support Program).

e. Health Maintenance and Acute Care Services

The costs of these services are based on a study of Medicaid utilization and expenditure patterns of residents in ICF-MRs in Georgia, California and Michigan conducted by Systemetrics/McGraw-Hill (Burwell, Clauser, Hall and Simon, 1987), and on a similar analysis of the costs of Medicaid expenditures for residents in Iowa group homes conducted by HSRI. These estimates are also informed by a study of the health care needs of persons with mental retardation and other developmental disabilities in the State of Massachusetts (Master, 1987).

It should be noted that these Medicaid-reimbursed costs probably represent only about 35% of actual costs and that the general medical cost figures assume the most expensive model of general medical (primary) care -- hospital-based outpatient services. These costs can be expected to decrease to the extent that the state is able to encourage the provision of clinical services apart from hospitals through the efforts of a service development team as recommended in Section V, and of the health service coordinators (nurse practitioners) recommended in Section I. Costs might also be reduced by raising physician fees allowed under Medicaid to the point where more physician services can be secured directly instead of through a hospital outpatient program. Such an effort is being piloted in the state of Massachusetts. The unit costs of acute care services are differentiated by age group since age is a significant cost determining variable. HSRI is not presently able to differentiate these costs by planning group reliably.

f. Specialized Client Support Services

The extent to which individuals will benefit from specialized services is best judged individually as part of the individual habilitation planning process. Even then there are differences among professionals as to the relative value of these services. This is by way of saying that the service utilization estimates presented herein are less bound to national norms than some of the other estimates.

HSRI's projections of service utilization rates draw primarily from two sources:

- Planning group-specific service utilization patterns of clients outplaced from the Pennhurst State Center in Pennsylvania as tracked by the Research and Evaluation Unit at Temple University. These unpublished data are judged to be reasonable figures in that services to these clients were given priority owing to the court order to close the Pennhurst facility and to the fact that the supply of specialists was not reported to be a significant problem in the Philadelphia area (Conroy and Bradley, 1985).

- The current levels of specialist staffing at GRC and Bainbridge which are both Title XIX-certified providers.

As expected some differences appear between the service utilization rates suggested by the staffing levels at GRC and Bainbridge, and as reported in the Philadelphia area community programs for outplaced Pennhurst residents. Most notably, the utilization rates for speech and hearing (communication) specialists are much higher in the community, while the utilization rates for psychologists and behavioral specialists are much lower.

At this stage the service utilization rates used in HSRI's projections hold to the level of service utilization implied by the number of specialist positions at GRC and Bainbridge, vacant as well as filled. The complement includes eleven full time equivalents (FTEs) at Bainbridge and 39 FTEs at GRC. Eleven hundred and fifty hours of service are assumed for each full time position based on a study of specialized serviced providers by Ashbaugh & Allard, 1984.

Based on service utilization data available in other states, these estimates will likely prove higher than actual experience. In part this is due to the limited number of specialists that will be available, and in part to the fact that community-based non-ICF-MR providers are typically not as inclined as ICF-MR providers to view specialized services as central to "active treatment." Should a decision be made to proceed with the development of community-based alternatives to GRC and Bainbridge, assessments of individual medical service needs will need to be completed.

While the level of specialized services overall is projected to remain unchanged in the move from institution to community-based services, the service mix has been changed. Speech and language (communication) service utilization rates are projected at higher than current levels in view of the increasingly recognized importance of communication in terms of skill building and controlling problem behaviors. Conversely, occupational therapy service utilization rates are projected to be lower than they are currently at GRC and BAINBRIDGE.The unit costs for these services are somewhat higher than current Medicaid fee schedules allow. The higher rates are judged to be necessary to attract and retain the services of these specialists.

g. Training

Thirty five hours of training are projected for each new residential and day program staff member at a total cost of $295. Thirty hours of annual training are projected for current staff at a total cost of $160. The cost figures are based on a community college based program of training formulated by HSRI for a comparable training model in Iowa. They include the cost of relief staff and travel. A turnover rate of 26% is used in projecting the number of new staff each year. This turnover rate was calculated from information obtained through the provider survey.

The number of residential and day service staff to be trained per client is estimated from the table of staff hours per client (Figure 4). One person from each personal care home is included in the estimated number of staff requiring training.

2. Projections

a. 1987

Appendix F presents the projected annual service requirements and costs by type of service and planning group assuming no change in the size of the target populations and other populations of concern. Figure 5 shows the service requirements and costs by service category for the 439 GRC residents and individuals awaiting service by category of service. The total cost is projected to be $25,323,572 currently with an average annual per diem of $158. The total cost for the 196 Bainbridge residents is projected to be $10,626,181 at an average per diem of $149. The largest share of these costs is for residential services.

Should the decision be made to serve the estimated 29 of the 376 individuals on the waiting lists in the four metropolitan Atlanta service areas studied whose disabilities are at a comparable level of severity to the GRC and Bainbridge target populations (planning groups 1-7), the cost would be another $11,876,088 at an average annual per diem of $156. Like costs for the estimated 136 of 221 individuals on the waiting lists in the three southwest Georgia MR/MR/SA service areas studied who are in planning groups 1-7 would be $8,628,167 at an average annual per diem of $165 Note: A policy of serving clients with

FIGURE 5: PROJECTED SERVICE DEMAND AND COSTS BY SERVICE CATEGORY BY TARGET SUBPOPULATION AND OTHER POPULATIONS OF CONCERN: 1987 AND 1992

1987

SERVICE CATEGORY>	CENSUS	ALL SERVICES PER DIEM	ALL SERVICES TOTAL COST	CLIENT MGMT SERVICES TOTAL COST	RESIDENTIAL SERVICES TOTAL COST	DAY SERVICES TOTAL COST	CLIENT SUPPORT TOTAL COST	HEALTH SERVICES TOTAL COST	CAREGIVER SUPPORT TOTAL COST
SUBPOPULATION:									
TARGET POPULATIONS:									
GEORGIA RETARDATION CENTER*	439	$158	$25,323,572	$1,342,901	$20,368,471	$2,048,649	$1,464,839	$589,850	$349,282
SOUTHWESTERN DEVELOPMENTAL CENTER AT BAINBRIDGE	196	$149	$10,626,181	$599,564	$8,120,191	$1,364,376	$626,260	$209,650	$81,740
SUBTOTAL	635	$155	$35,949,753	$1,942,465	$28,488,662	$3,413,025	$2,091,099	$799,500	$431,022
COMMUNITY WAITING LISTS**:									
COBB-DOUGLAS, DEKALB, FULTON&GWINNETTE SVC AREAS	209	$156	$11,876,088	$639,331	$8,660,605	$1,351,632	$1,124,196	$413,650	$83,214
DOUGHERTY, THOMAS, & LOWNDES SVC AREAS	143	$165	$8,628,167	$437,437	$6,772,195	$771,600	$634,494	$221,950	$59,711
SUBTOTAL	352	$160	$20,504,255	$1,076,768	$15,432,800	$1,992	$1,758,690	$635,600	$142,925
GRAND TOTAL	987	$157	$56,454,008	$3,019,233	$43,921,462	$3,415,017	$3,849,789	$1,435,100	$573,947

1992

SERVICE CATEGORY>	CENSUS	ALL SERVICES PER DIEM	ALL SERVICES TOTAL COST	CLIENT MGMT SERVICES TOTAL COST	RESIDENTIAL SERVICES TOTAL COST	DAY SERVICES TOTAL COST	CLIENT SUPPORT TOTAL COST	HEALTH SERVICES TOTAL COST	CAREGIVER SUPPORT TOTAL COST
TARGET POPULATIONS:									
GEORGIA RETARDATION CENTER*	485	$158	$27,977,067	$1,483,615	$22,502,753	$2,263,314	$1,618,330	$651,657	$385,881
SOUTHWESTERN DEVELOPMENTAL CENTER AT BAINBRIDGE	210	$149	$11,385,194	$642,390	$8,700,205	$1,461,831	$670,993	$224,625	$87,579
SUBTOTAL	695	$155	$39,362,261	$2,126,005	$31,202,957	$3,725,145	$2,289,323	$876,282	$473,460
COMMUNITY WAITING LISTS**:									
COBB-DOUGLAS, DEKALB, FULTON&GWINNETTE SVC AREAS	230	$156	$13,063,697	$703,264	$9,526,666	$1,486,795	$1,236,616	$455,015	$91,535
DOUGHERTY, THOMAS, & LOWNDES SVC AREAS	153	$165	$9,232,139	$468,058	$7,246,249	$825,612	$678,909	$237,487	$63,891
SUBTOTAL	383	$160	$22,295,835	$1,171,322	$16,772,914	$2,312,407	$1,915,524	$692,502	$155,426
GRAND TOTAL	1078	$157	$61,658,096	$3,297,327	$47,975,871	$6,037,552	$4,204,847	$1,568,785	$628,886

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* COUNTS INCLUDE PERSONS ON WAITING LIST FOR GRC SERVICES

** COUNTS INCLUDE ONLY PERSONS IN PLANNING GROUPS 1-7 equally severe disabilites (planning groups 1-7) on the waiting lists in *all* MH/MR/SA service areas would, of course, increase these costs appreciably.

b. 1992

Assuming that the size of the target populations and other populations of concern by age (0-5, 6-21, and 22 and over) change in proportion to the size of the general population by age, and assuming no inflation or deflation in unit costs, the projected size of these subpopulations and associated service costs would be as follows. GRC residents would number 485 with associated service costs of $27,977,067. Bainbridge residents would number 210 with associated service costs of $11,385,194. The metropolitan Atlanta area waiting list members would number 91 with associated service costs of $13,063,697. The southwest Georgia area waiting list members would number 153 with associated service costs of $9,232,139.

Though it is not possible to arrive at a per diem figure for GRC and Bainbridge comparable to our projections (given the different cost calculation methodologies), it is fair to say that the community costs will be only slightly lower than those in the institution. In addition to the fact that when in doubt HSRI chose to estimate service requirements on the high side, there are two other reasons for the rather narrow difference:

- In projecting the cost of community-based residential and day services, HSRI assumed that these providers would have salaries and fringe benefits comparable to those currently enjoyed by state employees. Salaries and fringe benefits represent the major portion of the costs of services for persons with mental retardation and other developmental disabilities whether they reside in an institution or in community based residences. As these are not projected to change, the largest portion of the per diems will remain stable.

  To project and plan for lower salaries and fringe benefits in community based programs would be to build a double standard into Georgia's system of service and salary reimbursement that is now plaguing many states. It is safe to say that eventually the pay and benefits system-wide will approach parity in most states but not without a lot of disruption that could have been avoided by holding to a single standard at the start.

- The level of functioning of the individuals at Bainbridge and GRC is low. These individuals require a great deal of supervision and support whether they reside at home, in the community, or in an institution. However, if the pattern of client development follows that of the clients placed out of the Pennhurst facility in Pennsylvania and from other state institutions, then the level of functioning for a number of individuals will improve and the cost of their supervision and support will correspondingly decrease.

C. Start-up Costs

1. Service-by-Service Analysis

The following types of community-based services must be in place to support residents outplaced from GRC and SDC. They are

- small ICF-MR's;
- group homes;
- minimally supervised and staffed apartments;
- work activity/sheltered work programs;
- supported employment programs;
- specialized support services (physical therapy, occupational therapy, communication, psychotherapy);
- crisis support programs
- medical support programs

Because the personal care providers and specialized service providers work strictly on a fee-for-service basis, there are no significant provider start-up costs that should have to be covered by the state. The administrative costs incurred by the state in promoting and assisting in the development of these services, however, are identified later as part of transition management costs for program planning and development.

The start-up period is generally divided into three phases: administrative, site occupancy and client transition. The first two phases require funding to cover one-time costs. The last phase requires working capital designed to keep the program in the black until full occupancy is reached at which time revenues should be sufficient to cover operating costs. The administrative phase includes those pre-operational activities necessary to establish the agency as a provider of service: hiring staff, planning and budgeting, obtaining start-up funds, facility siting, construction or remodeling, facility furnishing, and legal processes. Legal costs include the following, which the state may or may not opt to cover for private providers:

- Legal representation at site selection hearing;

- Legal representation at zoning board hearings.

It is assumed that the Department of Human Resources will fund full program costs during the resident transition period allowing the provider to recover revenue deficits. The extent to which providers are reimbursed for start-up costs (and for operating and capital costs) will, of course, influence the number of providers interested in developing and maintaining programs.

The costs of furnishings and equipment are not shown. These costs are shown as part of the capital costs estimates in the next section. Mortgage and lease costs include the cost of insurance. The residential mortgage costs are pegged to the capital cost estimates prepared by the architect. Rental costs are based on information from the Georgia Housing Survey and on discussions with realtors and providers in the metropolitan Atlanta and southwest Georgia areas. The lower rental and mortgage costs shown are for southwest Georgia; the higher, metropolitan Atlanta.

The occupancy phase includes those on site activities necessary to prepare for client admission: organizing staff training, licensing or certification, establishing working relationships with community support groups. The transition phase covers the initial period of service provision prior to reaching capacity.

a. Small ICF-MR Programs

1) Key Considerations

Title insurance and down payments may not have to be covered depending upon the method of financing. The model costed is for persons in planning group one -- the most expensive model.

2) Resource and Time Requirements

See Figure 6 which follows.

b. Group Home Facilities (4 beds)

1) Key Considerations

Compared to ICF-MRs, fewer staff and consultants must be hired and trained since the in-house programming is not as rich. Thus the time required for the administrative activities and the cost of staff training are less than projected for ICF-MR's. Finally, because the average per diem (estimated at $94) is less than the ICF-MR per diems, the cost of carrying the program at less than capacity during the period of resident transition is also less.

2) Resource Requirements

See Figure 7 which follows.

c. Staff and Supervised Apartments

1) Key Considerations

It is presumed that these arrangements will be in leased facilities.

FIGURE 6

ICF/MR SMALL (NEW) START-UP COSTS*

PHASE	ACTIVITIES	DURATION	BUDGET ITEM	COST
I. ADMINISTRATIVE	• Hire QMRP • Review resident applicants/screen residents • Develop & submit budget • Budget review • Recruit & hire staff • Contract with consultants	2 months (new)	Program Director (full time) @ $24,000/yr. With Fringe Benefits	$4,000
			Title Insurance	$800
			Clerical (half time) With Fringe Benefits	$1,200
			Down Payment @ 5%	$18,000
			Advertising	$500
			Legal Fees	$3,500
II. SITE OCCUPANCY			Mortgage/ Insurance @ 10%	$3,800-$4,200
	• Occupy facility	During 4th Month (new facility)	Utilities (1 Month)	$500
	• Title XIX certification activities		8 Direct Care Staff (1 wk) @ $12,000/yr. (with fringe benefits)	$3,250
	• Solidify community support service network • Establish standing operating procedures		Staff Training	$1,800
III. RESIDENT TRANSITION	• Transition of residents into the program over a 2 week period	1 Month	$176/day x 15 days x 6 clients	=$31,680

Total = $69,030 - $69,430

* 6 beds, ** Note New ICF-MR facilites are expected to range in size from 4 to 8 beds; the average facility will be 6 beds

FIGURE 7

GROUP HOME START-UP COSTS*

PHASE	ACTIVITIES	DURATION	BUDGET ITEM	COST	
				No Siting & Remodel	Siting & Remodel
I. ADMINISTRATIVE	• Hire Director • Review resident applicants/screen residents • Develop & submit budget • Budget review • Recruit & hire staff • Contract with consultants	2 months or 6 months with facility siting and remodeling	Program Director (full time) @ $24,000/yr. With Fringe Benefits	$4,000	$12,000
			Title Insurance	$600	$600
			Clerical (half time) With Fringe Benefits @ $7,000/yr.	$1,200	$3,600
			Advertising	$500	$500
			Down payment @ 5%	$6,000-8,700	$6,000-8,700
			Legal Fees	$2,500	$2,500
II. SITE OCCUPANCY	• Facility Licensing activities • Solidify community support service network • Establish standing operating procedures	During 2nd month or 6th month) o	Mortgage @ 10%	$1,500-2,100	$1,500-2,100
			Utilities (1 Month)	$500	$500
			4 Direct Care Staff (1 wk) @ $18,000/yr. (with fringe benefits)	$1,450	$1,450
			Staff Training	$1000	$1000
III. RESIDENT TRANSITION	• Transition of residents into the program over a 4 week period	1 Month	$94/day x 30 days x 4 clients = $11,280		
			TOTAL =	$30,530 - $33,830	$40,930 - $44,230

* 4 beds

2) Resource Requirements

See Figure 8 which follows.

d. Sheltered Work Programs

1) Key Considerations

The need to initiate new work activity and sheltered work programs may be lessened to the extent that existing participants can be moved into supported employment arrangements thus making way for outplacements from GRC and Bainbridge.

2) Resource and Time Requirements

See Figure 9 which follows.

e. Supported Employment

1) Key Considerations

Most outplaced residents, even those who may end up in supported employment, are projected to make the transition through existing sheltered work programs. This will allow some time to set up supported employment arrangements for individuals currently in the sheltered work programs who by moving into supported employment arrangements will make room for residents outplaced from the institutions. The sheltered work programs will also serve as backup resources for individuals who may need a new job placement.

The start-up costs of supported employment services will vary considerably depending on staff training and experience, the local economy, client capabilities and so forth. Because of the extended amount of time required to identify, contract and negotiate with existing businesses in establishing work arrangements (supported employment) as part of their operations (approximately one year), these programs are best started by persons detailed from ongoing organizations. HSRI suggests that they be started through sheltered

FIGURE 8

STAFFED SUPERVISED APARTMENT START-UP COSTS*

PHASE	ACTIVITIES	DURATION	BUDGET ITEM	COST No Siting & Remodel	 Siting & Remodel
I. ADMINISTRATIVE	o Hire Director o Review resident applicants/screen residents o Develop & submit budget o Budget review o Recruit & hire staff o Contract with consultants	2 months or 8 months with facility siting and remodeling	Program Director (full time) @ $24,000/yr. (With Fringe Benefits)	$4,000	$16,000
			Clerical (half time) @ $7,000/yr. (With Fringe Benefits)	$1,200	$4,800
			Advertising	$500	$500
II. SITE OCCUPANCY	o Facility Licensing/certification activites o Solidify community support service network o Establish standard operating procedrues	During 2nd month or 8th month	Rent	$1,800-3,600	1,800-3,600
			Security Deposit	$2,000	$2,000
			Utilities (1 month)	$500	$500
			4 Direct Care Staff (1 wk) @ $18,800/yr. (with fringe benefits)	$1,450	$1,450
			Staff Training	$1,000	$1,000
III. RESIDENT TRANSITION	o Transition of residents into the program over a 5-6 week period	1 month	$21/day x 30 days x 8 clients = $5,000		
			TOTAL =	$17,450-19,250	$32,850-34,650

* 8 beds in 3 to 4 apartments

FIGURE 9

SHELTERED WORK START-UP COSTS

PHASE	ACTIVITIES	DURATION	BUDGET ITEM	COST
I. ADMINISTRATIVE	o Incorporate o Develop & submit start-up budget o Recruit & hire director and staff o Review particpant applications	6 months	Program Director (full time) @ $24,000/yr. (with fringe benefits)	$12,000
			Clerical (half time) @ $7,000/yr. (with fringe benefits)	$3,500
			Travel	$2,000
			Advertising	$2,500
			Overhead @ 40% of labor & fringe benefits	$6,000
II. SITE OCCUPANCY	o Prepare & submit annual budget	During 6th month	Security Deposit (5,000 sq. ft. @ $12)	$6,000
			Rent 1 Month	$6,000
			Utilities (1 month)	$800
	o Arrange transportation		Staff @ $18,800/yr. (with fringe benefits)	$4,600
	o Establish standing procedures		Staff training	$1,500
III. PARTICIPANT TRANSITION	o Transition of residents into the program over a 6 week period	6 weeks	$35/day x 32 days x 30 clients =	$33,600

* 25 participants

Total=$82,700

employment programs now in operation.

There are no participant transition costs since clients would be engaged in the sheltered work program until they convert to supported work.

2) Resource and Time Requirements

See Figure 10 which follows.

f. Medical Support Unit

1) Key Considerations

The acute care costs projected in this section should be ample to cover the cost of the startup as well as ongoing cost of this service. Because of the unique nature of the service, the budget will likely have to be negotiated and the service funded on a program rather than fee-for-service basis.

The annual budget is estimated based on the budget of a similar program in Nebraska. The cost of medical supplies are largely covered through Medicaid and other third party insurers.

2. Resource Requirements

See Figure 11 which follows.

FIGURE 10

SUPPORTED EMPLOYMENT PROGRAM START-UP COSTS

PHASE	ACTIVITIES	DURATION	BUDGET ITEM	COST
I. ADMINISTRATIVE	o Develop & submit o start-up plan & budget o Recruit & hire director and staff o Review particpant applications o Develop business & contract for work o Staff training & technical assistance	6 months	Program Director (half time) @ $26,000/yr. (with fringe benefits)	$26,000
			Clerical (half time) @ $14,000/yr. (with fringe benefits)	$14,000
			Training/ consultants (supported employment)	$5,000
			Travel	$2,500
			Advertising	$2,500
			Overhead @ 40% of labor & fringe benefits	$14,000
II. SITE OCCUPANCY	o Prepare annual plan & budget o Prepare work plan o Prepare clients for work	6th months	Rent 1,000 sq. ft @ $12	$6,000
			Utilities (1 month)	$1,500
			Staff @ $20,000/yr. (with fringe benefits)	$30,000
			Staff training	

* 15 participants

TOTAL = $108,500

FIGURE 11
MEDICAL SUPPORT UNIT START-UP COSTS

24 hour RN Care

BUDGET ITEM	COST
Program Director	$30,000
Registered Nurse Supervisor	$24,000
4.5 Registered Nurses (@ $22,000 including fringe benefits)	$99,000
4.5 Residential Workers (@ $18,800 including fringe benefits)	$84,600
Consulting Physicians (@ $60 per hour)	$35,000
Consultant Therapists (@ $30 per hour)	$15,000
Other operating expenditures	$58,000
TOTAL	$384,000

g. Crisis Support Program

1) Key Considerations

Staff offices would be located at the respite home. There would be no transition costs given the crisis nature of the services.

2) Resource Requirements

See Figure 12 which follows.

2. Projections

Figure 13 presents the projected startup costs by study subpopulation and type of program. With the exception of the work activity and sheltered work programs, 100% of the persons in the study populations are projected to enter new programs. Thirty percent of the work activity and sheltered work programs are estimated to have the ability to expand their current capacity to accommodate individuals in the study populations. Because all pre-school programs are projected to

FIGURE 12

CRISIS SUPPORT START-UP COSTS*

PHASE	ACTIVITIES	DURATION	BUDGET ITEM	COST	
				No Siting & Remodel	Siting & Remodel
I. ADMINISTRATIVE	o Hire Director o Develop & submit budget o Budget review o Recruit & hire staff o Contract with consultants o Arrange for psychiatric backup (consultation & beds)	4 months or 8 months with facility siting and remodeling	Program Director (full time) @ $28,000/yr. (With Fringe Benefits)	$8,000	$16,000
			Title Insurance	$600	$600
			Clerical (half time) @ $7,000/yr. (With Fringe Benefits)	$2,400	$4,800
			Advertising	$1,200	$1,200
			Down payment @ 5%	$9,600-$13,900	$9,600-$13,900
			Legal Fees	$2,500	$2,500
II. SITE OCCUPANCY	o Facility Licensing activitities o Solidify community support service network o Establish standing operating procedures	During 4th or month or 5th month	Mortgage @ 10%	$2,400	$2,400-3,000
			Utilities (1 month)	$500	$500
			5.5 Direct Care Staff (1 wk) @ $22,000/yr. (with fringe benefits)	$2,350	$2,350
			Staff Training	$2,500	$2,500

* 5 beds

TOTAL = $28,950-33,850 $41,850-46,750

FIGURE 13: PROJECTED START-UP COSTS BY TYPE OF PROGRAM AND STUDY SUBPOPULATION

PROGRAM REQUIREMENTS/SUBPOPULATION:

SERVICE TYPE	PERSONS NEEDING SERVICE GAC	PERSONS NEEDING SERVICE SDCB	PERSONS NEEDING SERVICE ATL MTG	PERSONS NEEDING SERVICE SW GA MTG	% ENTERING NEW PROGRAM	NEW PROGRAM SLOTS REQUIRED GAC	NEW PROGRAM SLOTS REQUIRED SDCB	NEW PROGRAM SLOTS REQUIRED ATL MTG	NEW PROGRAM SLOTS REQUIRED SW GA MTG	AVERAGE PROGRAM CAPACITY	# OF NEW PROGRAMS NEEDED GAC	# OF NEW PROGRAMS NEEDED SDCB	# OF NEW PROGRAMS NEEDED ATL MTG	# OF NEW PROGRAMS NEEDED SW GA MTG	TOTAL NEW PROGRAMS NEEDED	START-UP COSTS PER PROGRAM METRO ATL	START-UP COSTS PER PROGRAM SW GA	TOTAL START-UP COSTS GAC	TOTAL START-UP COSTS SDCB	TOTAL START-UP COSTS ATL MTG	TOTAL START-UP COSTS SW GA MTG
RESIDENTIAL:																					
ICF-MR sal(New/Non-amb)	107	21	28	25	100%	107	21	28	25	6	18	4	5	4	30	$69,450	$69,030	$1,238,168	$241,605	$324,007	$287,625
Grp Hm sal(Renov/Non-amb)	78	7	8	12	100%	78	7	8	12	4	20	2	2	3	26	$44,230	$40,930	$862,485	$71,628	$88,460	$122,790
Grp Hm sal(Renov/Amb)	186	131	134	132	100%	186	131	134	132	5	37	26	27	26	117	$33,830	$30,530	$1,250,476	$799,886	$906,644	$803,992
Apts;Renov/Amb)	4	3			100%	4	3	0	0	2	2	2	0	0	4	$34,650	$32,850	$69,300	$49,275	$0	$0
EDUCATIONAL/ VOCATIONAL: Work Activity/ Sheltered Work	101	56	96	51	70%	71	39	67	36	25	3	2	3	1	9	$33,600	$33,600	$95,021	$52,685	$90,317	$47,981
Supported Employment	101	55	95	51	100%	101	55	95	51	15	7	4	6	3	20	$108,500	$108,500	$730,567	$397,833	$687,167	$368,900
OTHER COMMUNITY SUPPORT SERVICES																					
Medical Support Unit					Unknown	0	0	0	0	0	1	0	0	0	1	$96,000		$96,000	$0	$0	$0
Crises Support Unit					Unknown	0	0	0	0	0	1	1	0	0	2	$33,850	$28,950	$33,850	$28,950	$0	$0
Total											88	39	42	38	208			$4,383,867	$1,641,862	$2,096,594	$1,633,288

Note: Totals may be off slightly due to rounding

199

20

be able to expand to accommodate the few children in the study population, pre-school programs are not shown on this table.

Although HSRI cannot be certain that a medical support unit will be needed in the metropolitan Atlanta area, the start-up costs for the unit (at 25% of the estimated annual budget) are included in the event that it is. Along the same line, HSRI's projections of the demand for crisis support services among the study population is not, alone, sufficient to warrant the development of crisis support services in either the Atlanta or southwest Georgia service areas. However, the unmet demand for these services identified in the provider survey was quite high. In order to assure that crisis support services are available should they indeed be found necessary, HSRI is including estimated startup costs for one unit in the Atlanta area and one unit in the southwest Georgia area.

The total program startup costs associated with serving members of the target population amounts to $6,025,729. The total program startup costs associated with serving persons in planning groups 1-7 awaiting service in the seven MH/MR/SA service areas studied are $3,729,882. The total estimated startup costs overall are $9,755,611.

D. Capital Costs

1. Base Data and Assumptions

Prototypical plans and relevant cost factors have been prepared for four major residential options, with sub-options as noted:

1. Apartments (2-3 beds); renovated buildings for both ambulatory and nonambulatory residents.

2. Small Group Homes (3-5 beds); renovated buildings for both ambulatory and nonambulatory residents.

3. Large Group Homes (6-8 beds); new construction and renovated buildings for both ambulatory and nonambulatory residents.

4. Small ICF-MR (6 beds); new construction for both ambulatory and nonambulatory residents.

These residential options are distinguished by standards for administration, care provided, and for physical facilities as established in regulations of the Georgia Department of Human Resources, which in turn related to the Department's standards for the resident populations to be served in each type of setting. It is understood that, with the exception of the apartment of option, each type of facility listed above is governed by the "Rules and Regulations for Personal Care Homes" (1981) and the "Minimum Requirements for Group Homes 1974," or the "Rules and Regulations for Intermediate Care Homes" (1976). In addition, since building codes will vary from one locality to another, the "Proposed Rules of Safety Fire Commissioner, Chapter 120-3-21" (1986) have been used as a conservative standard for this study. This document makes substantial reference to the "Life Safety Code," NFPA 101, 1985 edition. Intermediate Care Facilities are also regulated by Federal Title XIX standards when reimbursement is involved. These regulations also incorporate the ANSI A117.1 standards for accessibility and usability for persons with physical handicaps. ANSW has typically been used as a guide for facilities for nonambulatory residents. The requirements of Intermediate Care Homes are the same for ambulatory as nonambulatory residents. It is understood that Apartments, as a residential setting for independent living, are not governed by the regulations described above, but rather only by local building codes and zoning ordinances.

The prototypical models for each of the residential options in this study were selected to optimize their match with the codes and regulations (See Appendix H) For residential options involving renovation, we have utilized examples of housing typically available in most communities, which in turn will minimize the amount of reconstruction necessary for the proposed use. Hence, the apartment model for nonambulatory residents assumes the use of apartments already constructed to provide access for handicapped persons to the apartment unit and adequate space within bathrooms and kitchens without further improvements to the building. Other renovation options assume existing buildings of sufficient size and number of bedrooms, appropriate number of bathrooms, adequate width of halls, etc. (Seventy square feet per bed was used as a *minimum* standard for bedrooms, or higher as required by specific regulations.) Models for new construction options have been designed to meet the applicable codes and regulations and to provide normalized, home-like environments. These residences will be capable of both providing supportive settings for the residents' development, and also be complementary inconspicuous additions to existing neighborhoods.

Construction costs have been estimated for the actual renovation work or new construction anticipated for each residential option. The "Construction Cost Data, 1987" published by R.S. Means Company, Inc. have been used as a basis for these cost projections. As in the case of the other costs in this analysis, these are current for 1987 and will need to be escalated for future application. We have tested these costs against comparable experience in both northern and southern parts of Georgia. While the actual construction costs will vary even within one region, we have used the conservative higher estimates for both the high and low ranges of the probable costs.

The likelihood is that the available housing stock will be more suited in size to small than large group homes. Thus, the cost projections suggest that it will be more economical to build new rather than renovate large group homes because of the greater number of residents that can be served within a facility that is designed specifically for that purpose.

As in the case of construction costs, the acquisition costs vary widely between different parts of the state. A review was conducted of acquisition costs in seven counties and two counties, DeKalb and Lowndes, were selected to represent the typical upper and lower extremes of real estate building and land sales costs based on data supplied to use. Development costs include architectural and engineering fees, legal costs, and real estate brokers' fees and are estimated at 10% of the combined construction and acquisition costs. Finally, furnishings and equipment costs have been estimated for each facility.

The total costs are expressed as per site and per bed, and show the range created by the high and low projections for acquisition costs in the different parts of the state. The basic case assumes all bedrooms in a facility available for residents, with staffing on a shift basis. The total costs are further delineated to reflect the case of sleep-in staff in the group home models, and therefore the dedication of one bedroom to staff use and the reduction of one in the number of residents served in the facility. Again, all these estimates should be escalated for applications after 1987.

2. Projections

Figure 14 presents the projected capital costs for new facilities to accommodate the study subpopulations by subpopulation and type of program. The number of persons who require fully accessible residential arrangements for nonambulatory individuals are estimated from the ICAP and waiting list data. All of the ICF-MRs are projected to be newly constructed to non-ambulatory (non self-preserving) standards.

Based on surveys of realtors in the service areas studied, and considering the residential siting strategy suggested in Section IV, the supply of existing small group homes is projected to be sufficient to accommodate nearly all of those individuals who are ambulatory in the

FIGURE 14: PROJECTED PROGRAM CAPITAL COSTS BY TYPE OF PROGRAM AND STUDY SUBPOPULATION

PROGRAM REQUIREMENTS/SUBPOPULATION:

SERVICE TYPE	PERSONS NEEDING SERVICE				NEW PROGRAM SLOTS REQUIRED				AVERAGE PROGRAM CAPACITY	% REQUIRING NEW OR RENOV FACILITY	# OF NEW PROGRAMS NEEDED				TOTAL NEW PROGRAMS NEEDED	CAPITAL COSTS PER PROGRAM		TOTAL CAPITAL COSTS			
	GRC	SDCB	ATL UTG	SW GA UTG	GRC	SDCB	ATL UTG	SW GA UTG			GRC	SDCB	ATL UTG	SW GA UTG		METRO ATL	SW GA	GRC	SDCB	ATL UTG	SW GA UTG
RESIDENTIAL:																					
ICF-MR sal(New/non-amb)	107	21	14	22	107	21	14	22	6	100%	18	4	2	4	27	$333,390	$323,265	$6,305,680	$1,138,428	$825,043	$1,192,638
Grp Hm sal(Renov/Non-amb)	78	7	8	12	78	7	8	12	4	100%	20	2	2	3	26	$174,550	$110,750	$3,403,725	$193,813	$349,100	$332,250
Grp Hm sal(Renov/Amb)	186	131	134	132	49	15	15	13	5	10%	4	3	3	3	12	$169,050	$105,250	$628,866	$275,755	$453,054	$277,860
Apts(Renov/Amb)	4	3			4	3	0	0	2	100%	2	2	0	0	4	$87,300	$48,600	$174,600	$102,900	$0	$0
Total	375	162	156	166	207.6	44.1	35	47			43	9	7	9	69			$10,512,879	$1,710,895	$1,627,197	$1,802,748

Note: Totals may be off slightly due to rounding study subpopulations. The renovation of facilities will only be required for an estimated 10% of persons who are ambulatory in the study subpopulations.

The total capital costs projected for the target populations is $12,223,774. The total capital costs projected for individuals in planning groups 1-7 awaiting residential services in the MH/MR/SA service areas is estimated to be $3,429,945. The total estimated capital costs are $15,653,719.

IV. WHERE WILL THE MONEY COME FROM?

Should GRC and Bainbridge be closed, funds will be required to underwrite the one-time cost of managing the transition process, start-up and operation of community alternatives, and the construction of some facilities. There will also be one-time residual costs associated with the closing that are not addressed in this report. This section identifies and briefly describes alternative sources of funding that can be used for these purposes.

Absent a specific legislative action, the proceeds resulting from sale of state lands or other savings would revert to the state general fund. However, such funds could also be reserved for use in the development and operation of services for the target populations and other populations of concern through an act of the legislature. Comparable arrangements have been or are being formulated in the states of Colorado, Alaska and Arizona. During the site visit to Arizona, the Steering Committee learned that the legislature had placed the proceeds from the sale of an institutional campus into a trust fund solely for the development of new services for persons with mental retardation and other developmental disabilities. The operation of the fund is overseen by a board who receive, review and themselves prepare proposals for the use of these funds.

A. One-Time Cost of Transition

Most of these costs will legitimately be included as direct and indirect expenses under Title XIX reimbursed through the GRC and Bainbridge ICF-MR rates.

The Job Training Partnership Act (Title III) provides a potential source of funding for retraining staff from GRC and Bainbridge. The Act provides for the allocation of federal funds to each state on the basis of a formula considering the number and size of the economically disadvantaged areas in the state, state unemployment rate, and population. The purpose of these funds is to help retrain people who lose their jobs due to plant closings and other economic downturns not of their own making. In addition, there is a "dislocated worker discretionary fund" designed to address specific targeted groups of people effected by mass layoffs.

B. Start-Up Costs

If, as expected, the state continues to utilize Title XIX funds to support the community-based network of services for the target populations and other populations of concern, start-up costs may be recovered through Medicaid. In addition to the start-up costs in Section III, Title XIX funds can be used to cover the costs of furnishings and equipment. However, the startup costs must be amortized over an extended period. The problem thus becomes one of cash flow. One solution would be for the state itself to loan startup funds to providers requiring them to repay the loan through recoveries via future Medicaid payments. This is done in New York through a revolving loan fund. The state can guarantee repayment by placing a first claim on all payments.

C. Operating Costs

In order to retain the federal share of funding (63.04 % in fiscal year 88/89) available to the GRC and Bainbridge populations under Title XIX, the state could opt simply to out place residents in a comparable number of ICF-MR beds in small community facilities. However, HSRI recommends that at least for those clients at skill level IV who do not have overriding behavioral, physical or medical problems (planning groups 1 and 2) the state apply for another Home and Community Based Services Waiver to the Health Care Financing Administration. The waiver would cover services to the target population and to those like individuals awaiting services in the community who would otherwise be placed at GRC or Bainbridge.

HSRI recommends that the state pursue a combination of these two strategies: developing and certifying small ICF-MRs for those individuals with overriding medical and physical problems in planning group one and optionally for some individuals in planning groups 2, 3 and 4. Services for all other individuals should be covered through a Home and Community-Based Waiver.

Although the cost of ICF-MRs versus waiver programs will not differ significantly, and even though ICF-MRs are not subject to and contingent upon periodic renewal as is the case with the waiver funds, the waiver approach appears to be the better strategy for most individuals in the target population and other populations of concern for the following reasons. First, unlike the ICF-MR strategy, the waiver strategy will allow the state the flexibility to provide appropriate and cost effective complements of services to clients over time. It allows for a client-oriented strategy rather than a provider-oriented strategy. As evidenced by the cluster management approach piloted in Dalton County which funds new residential services on a level-of-care approach, a client-oriented approach to system management of funding is the direction in which Georgia (like most other forward-looking states) is headed. It is also the approach that characterizes attempts at the federal level to reform Title XIX and is a key provision in the Chaffee bill which now has 22 co-authors and the support of 20 national organizations..

Not only is the waiver strategy consistent with this funding and broader systems management approach, but it will allow the state to utilize Title XIX funds to develop the information and control systems necessary to make it work. Specifically, it will allow the Division of MH/MR/SA to resolve the following issues of concern identified in Part One of this report.

- The establishment of a practical, valid and verifiable procedure for evaluating client level-of-care requirements;

- The development of a carefully conceived model of habilitative service by level-of-care comparable to that recommended in Part Two Section III, but more refined and tailored to fit the Division's policies, objectives and situation. The model needs to provide for sufficient resources to ensure appropriate and adequate levels of client care;

- Integrated quality assurance/case management/cluster-system management procedures designed to broker and promote a cost-effective complement of services for each individual;

- The relaxation of those departmental fee limitations and expenditure guidelines that restrict the use of various service options for clients. For instance, at present the reimbursement rates for developmental training homes are fixed irrespective of the level of care demanded for the residents. Similarly, the rates allowed for supported employment are fixed irrespective at a client's level-of-functioning. Any service-specific rates, under the per capita method of allocation will need to be more flexible and more attuned to client service demands; and

- The development of budget and expenditure reporting and auditing procedures consistent with this capitated mechanism of fund allocation.

The waiver request could be patterned after that recently approved for the State of Nebraska. Nebraska's waiver plans and cost projections are built around different models of "habilitation services" for different client groups. The waiver provides for a capitated client-based approach to funding like that recommended in this report.

The risk that the waiver may not be renewed is not as great as it might appear at first glance. As a contingency, the state should be able to certify most of the expensive waiver-supported residential providers under the ICF-MR umbrella and retain Title XIX funding. Moreover, the risk of possible nonrenewal must be weighed against the risk associated with a heavy investment in the ICF-MR program, specifically:

- Congress may apply an overall cap on state Title XIX funding;

- Without exception, those states having invested heavily in small ICF-MRs will attest to the difficulties involved in moving to less expensive and more flexible models of care in the face of a strong ICF-MR lobby;

- Published forecasts point to the eventual predominance of family and family-like supported models of care (Putnam & Bruininks, In press; Roos, 1978; and Hillier & Klas, 1984);

- ICF-MRs may be decertified. It is important to remember that according to ICF-MR standards, an ICF-MR must provide "active treatment services" to all residents (42 CFR 442.435). "A state which fails to build into its programs assurances that each certified home has the capability of delivering a full range of active treatment services is very likely to find that its facilities are in constant jeopardy of decertification" (Gettings, 1986). As discussed elsewhere in this report, the inclination of many federal surveyors to view professional therapists as a key ingredient in an active treatment service capability and the widespread shortage of these individuals in Georgia, makes the the prospect of decertification of large or small ICF-MR facilities is a distinct possibility. In fact, in discussions with federal ICF-MR surveyors, there is every indication that the latitude allowed ICF-MRs in this area is likely to decrease over the next several years.

It is also important to recognize that the higher the level of resident functioning in an ICF-MR, the greater the risk of HCFA challenges to the eligibility (need for) ICF-MR care during look-behind reviews or other auditing activities.

D. Capital Costs:

The central policy issue relating to the funding of capital costs is whether development should be undertaken through a model that places most of the burden of accessing capital markets on providers, or one in which the state serves the function of financier. If providers are expected to marshal capital, there will be two principal disadvantages: (1) larger agencies will need to be relied upon to develop programs since such agencies will appear to be sounder risks to lenders, and (2) development and plan implementation will be slower since there is usually a good deal of "start and stop" behavior when providers are engaged in the capital markets.

At the least, state should assist providers in accessing federal and private capital by lending their expertise and the expertise of others to providers through a well-planned program of training and technical assistance as recommended in Section V. However, the state may wish to go even further by actually helping providers apply for federal funds or, in the case of private funds, setting up a public/private finance authority. This authority would utilize state guarantees for payments in order to access private capital. Connecticut has taken this approach. The finance authority secures private investor funds, constructs facilities and "turnkeys" facilities to providers. Operators pay rent to the authority and the authority retains title to the facility. Consequently, in the event of provider failure, the facility is not lost.

Federal and private funding streams available to cover capital costs are outlined below.

1. Federal Sources

a. Broad Range of Housing Activities.

- The Community Development Block Grant (CDBG) (Federal program) can be used for any type of housing needed for persons with mental retardation or other developmental disabilities. These funds can be used to support the acquisition, rehabilitation, and in some cases even new construction of housing;

- The Farm Home Loan Administration, Community Facilities Loan Program. This program can be used to provide long-term, low-cost loans. Interest rates currently run around 7%. There is a minimum or no down payment required and the loan may be written for up to 40 years. These monies may also be used in conjunction with the CDBG grants to fulfill the 1/3 local match requirement. The Section 8 Existing Housing Certificate and Voucher programs (Federal program) may be used to provide rent subsidies in most types of housing developed for persons with mental retardation.

b. Personal Care Homes

In addition to the federal programs mentioned above that might be used to provide board and care facilities, Section 232 insurance (Federal program) can be used to insure a loan for the construction or renovation of a board and care home. Sources of loan funds could be private lenders, or state mortgage revenues bonds (state program). It should be noted, however, that the availability of funding under these programs is currently severely limited.

c. Community Supervised Living Arrangements (Small Homes)

Aside from CDBG and Section 8 programs, other programs include:

- The Section 202 Direct Loan Program for Housing for the Elderly and Handicapped (federal program) which can be used for acquisition, rehabilitation, or new construction of group homes and community supervised living arrangements. This program has an accompanying rental assistance subsidy under the federal Section 8 program;

- The Section 8 Moderate Rehabilitation Program (federal program) which provides rental assistance subsidy to cover costs associated with operating rental housing and paying off a loan which was used to renovate the property;

- The Rental Rehabilitation Program (federal program) which provides grants of up to $5,000 per unit, which must be matched by other funds, to renovate residential rental units. Rental Rehabilitation funds may be accompanied by Section 8 certificates or vouchers (federal program) which provide rental assistance for the tenants;

- Section 203(b) insurance (federal program) can be used in connection with a loan to purchase 1-4 family housing for group home use;

- Housing suitable for group homes may be available for purchase from Federal agencies that have acquired them through foreclosure (Federal program) or local governments that have acquired them through tax foreclosure;

- Funds to purchase group homes, supervised community living arrangements and halfway homes may be available from private sector sources (private sector).

4) Community Supervised Living Arrangements (Apartments)

All programs mentioned above for group homes (except 203(b) insurance) may also be used in connection with apartment complexes. In addition, the following avenues should be pursued:

- The local public housing programs (Federal program) may be a source of apartment units for clients to rent. Additionally, the Public Housing Agency may know of rental units available under the Section 8 Moderate Rehabilitation or Rental Rehabilitation programs.

- The Section 221 (d)(4) insurance program (Federal program) can be used to insure a loan for the construction of apartment complexes of more than five units. Financing may be available through Limited Partnerships or Syndication (private sector approaches) or State mortgage revenue bonds financing (State program).

- The Section 234 mortgage insurance program (Federal program) can be used to insure loans to develop cooperative housing of five or more units.

- Individuals, non-profit groups and local housing agencies have all successfully formed limited partnerships and syndications in order to pool resources for the purchase and management of residential arrangements for persons with MR/DD. Although recent changes in the income tax laws now limit the tax sheltering advantages of these arrangements, partnership arrangements still hold some advantages to investors.

2. Private Sources

Generally speaking, federal sources for financing housing are rapidly diminishing. Therefore, greater attention is being given to identifying new and more creative solutions to finance housing development for populations with special needs. Private sector funds are considered by many experts to represent a rich, and largely untapped source of funding potential for housing development.

MR/DD agencies provide investors with the opportunity to avoid the three largest disincentives in real estate investment -- vacancy rates, property management, and maintenance. Since low occupancy rates reduce the investor's profit, agencies can establish long-term agreements with the investors to guarantee 85-100% occupancy at a fixed rent level. Similarly, if any agency or organization assumes responsibility for managing the property, it can also save the investor considerable time and money. The investor may even be willing to renegotiate lower rents in exchange for this service. Some responsibility for maintenance could also be assumed by the agency/organization which could teach tenants to do some of the chores (e.g., gardening, minor repairs). This would allow the tenants to become more invested in their housing, while the investor would continue to take care of the larger and more expensive maintenance tasks.

It is also possible for a consumer to own his or her own home by using either personal resources (e.g., SSI/SSDI, savings), or those of the family, to acquire the property. Home ownership may be shared through cooperative and condominium arrangements. Consumer home ownership can also be achieved through other strategies as well, such as lease purchase agreements in which the investor relinquishes titles to the tenant/lessee after payment of a stated amount of rentals. Residents may own their own homes alone, as tenants in common, as joint tenants, as tenants in the entirety or as a partnership.

Some families can afford to purchase individual housing units for their disabled relatives. Families may also be able to set up life estate trusts that allow families to donate their homes to a non-profit agency for use by a disabled relative.

Some family groups have organized themselves into private non-profit corporations, the primary purpose of which is to develop, operate, and preserve housing units that will remain affordable for their family members for an extended period. The corporation maintains a tax-exempt status by operating exclusively for charitable purposes and by having no part of its net earnings benefit any of the private shareholders.

V. HOW SHOULD THE TRANSITION BE MANAGED, HOW MUCH WILL IT COST, AND HOW LONG WILL IT TAKE?

This section outlines the activities that must be undertaken to manage the phase down of GRC and Bainbridge, the corresponding build-up of community-based programs, and relocation of the target populations and staff. It also presents budget estimates for the transition management activities.

A. Project Management

1. Discussion

The Division of Mental Health, Mental Retardation and Substance Abuse is organized to fulfill state level functions of an ongoing nature and is not organized to implement the major system change process involved in the movement from hospital to community-based care. Should the decision be made to develop community alternatives to GRC and Bainbridge, a project team must be established that is dedicated to the planning and implementation of the process. A project team is essential for an undertaking of this magnitude to be effected in an expeditious and orderly fashion.

The management unit should be located within the Georgia Division of Mental Health, Mental Retardation and Substance Abuse. It might operate under contract during the course of the project, or it might be staffed as a "special project" unit to carry out other such time-limited initiatives in the future. The management team should prepare plans for implementing the system changes recommended herein, and should serve as the focal point for all activities outlined in the plans. The project team should be involved in all major decisions concerning costs, timing and plan modifications. The team should become involved at the very beginning of the planning process, starting with the update and refinement of HSRI's implementation recommendations and preliminary plan and should continue to oversee the implementation process throughout the transition period.

The team's planning and coordination activities should include:

- the assessment, preparation, relocation and follow-up of members of the target population;

- the development of residential, day, health care, and support services to accommodate outplaced residents;

- the planning and coordination of staff reassignments, relocations, retraining and support;

- the development of a steering committee of key actors and interests in order to keep the public informed as the project progresses and to provide for the active participation of decision makers, administrators and others concerned in the reconfiguration process.

The project director should be a capable individual to whom as much discretionary decision-making power as possible should be delegated. The project director should have a deputy at each of the two institutions capable of picking up the project should the director become temporarily or permanently unavailable to the project.

Ideally, each deputy project director should be selected from the management staff at the institutions if such person can be spared from regular duties. If not, s/he should have institutional experience and should be generally known within the Department for his/her objectivity and humane diplomacy. Staff chosen from the institution are assured of the following:

- an implementing work force of middle managers, aides and secretaries,

- a familiarity with the institution/unit being closed, and of its special staff, patient, political supports and obstacles,

- a care in planning and implementing which is usually exercised only by those who have to live with the results,

- a guarantee of a conscientious follow-up.

The Division of MH/MR/SA should form a Steering Committee (SC) representative of, (a) the main administrative players related to the closing, (b) the main citizen groups related to the closing, (c) selected support persons, (d) client advocates, and (e) staff representatives.

The rationale for this recommendation is that every concerned and related group will be either an advocate or an opponent; none will be neutral. The inclusion as participant in the closing process enhances the likelihood of ultimate consensus. In addition, the inclusion of a variety of relevant and caring perspectives will insure a responsible, humane and prudent process.

The committee should be advisory to the project director, and should be so informed at its first meeting. It would advise on the planning and coordination of the entire closing project, and advise and assist in planning and executing whatever announcements and public relations functions might be required.

The deputy project directors would be responsible for coordinating institutional efforts with community-based case and cluster managers. Resident relocation should also be coordinated with staff relocation and reassignment efforts, and program planning and development efforts.

A coordinator for program planning and development should also be part of the team. This is a particularly important position in view of the rapid pace at which community-based services would have to be developed. Reporting to the coordinator should be two program development specialists whose charge would be to expedite the creation of the new services required and to provide technical assistance to these providers. The coordinator would coordinate the work of the provider support teams discussed in Section D.

Consultants may be used to help expedite the capitation system/waiver development.

2. Budget Estimates

An annual operating budget is shown below.:

Staff:

Budget Item	Amount
Project Director	$ 40,000
Deputy Directors	$ 64,000
Coordinator, Program Development	$ 30,000
Program Development Specialists (two)	$ 56,000
Administrative Assistant	$ 20,000
Subtotal Salaries	$210,000
Fringe Benefits @ 36.5% =	$ 76,650
TOTAL STAFF	$286,650

Other:

Furnishings and Equipment	$ 10,000
Rent (2,000 sq. ft. @ $20)	$ 40,000
Postage ($150 @ month)	$ 1,800
Supplies	$ 5,000
Phone/Messenger ($600 @ month)	$ 7,200
Travel	$ 12,500
Printing	$ 10,000
Startup Costs/Working Capital	$ 12,000
Consultant Services	$100,000
Miscellaneous	$ 6,000
Subtotal	$204,800
TOTAL	$491,450

B. Resident Preparation/Relocation and Follow-Up

The impact of the movement of individuals from one facility to another has long been an area of concern to researchers in the fields of mental health, gerontology and mental retardation. Some studies in the gerontology literature indicate that relocation leads to increased mortality rates for individuals (Kasl, 1972; Aldrich & Mendkoff 1963; Marlowe, 1973). The psychiatric literature indicates negative impacts as well, including death, illness or psychological deterioration post relocation (Kral, Brad & Berenson, 1968); Miller & Liberban, 1965). One of the earliest studies on the relocation of persons with mental retardation produced similar results (Miller, 1975). In Miller's study, which involved individuals labeled profoundly mentally retarded relocated from Pacific State Hospital al in California to convalescent hospitals, mortality was reported to have increased two fold.

However, there is a growing body of literature that indicates that there may actually be a decrease in mortality rates for elderly people who are relocated (reviewed in Borup, Gallego, & Haffernan, 1979) and for people with mental retardation (Cohen, Conroy, Frazer, Snellbacker, & Spreat, 1977). The Cohen et al. study examined the effects of relocation on 92 individuals with mental retardation from a large public institution in Pennsylvania to a smaller facility. The authors reported significant deterioration in the area of maladaptive behavior among lower functioning individuals. In a follow-up report, Conroy and Spreat (1978) found that the negative consequences of relocation did fade, but that it took approximately six months. Carsrud, Carsrud, Henderson, Allisch, and Fowler (1979) replicated these findings in Texas, using direct observation of social interaction. They also suggested careful planning for a gentle transition, and supported the notion that people with mental retardation of all levels are sensitive to, and can be be adversely affected by environmental change.

While the literature reports the possibility of stress reactions in institutional transfers, these effects can be minimized or prevented through the proper management of the relocation process, both clinically and administratively (Heller & Braddock, unpublished working paper). Some studies in the area of placement from institutional to community based settings have found that individuals actually benefited from the relocation, demonstrating progress in the areas of self-help, socialization and communication (Aanes & Moen, 1976; Close, 1977; Conroy, Efthimiou, & Lemanowicz, 1982).

As the Cohen et al. study demonstrated, the effects of relocation may be stronger for some groups than for others. Several studies have looked at the relocation phenomenon examining the effects of residents' physical health, level of mental retardation and age on post relocation adjustment. Some studies have been found to show that those individuals with the poorest health may suffer the most from relocation (Goldfarb, Shahinian & Burr, 1972; Heller, 1982; Killian, 1970; Marlowe, 1973). The results with regard to level of mental retardation and its impact on relocation are mixed. While the Cohen et al. study showed increased skills for those individuals labelled profoundly retarded. Hemming, Lavendar, and Pill (1981) demonstrated that higher functioning people showed increases in language development, and lower functioning people expressed greater levels of withdrawal and maladaptive behaviors. In the Pennhurst Study Conroy and Bradley (1985) found that those individuals labeled profoundly mentally retarded benefited the most from relocation to the community in terms of increases in adaptive behavior.

In looking at this information as it relates to the State of Georgia, it is clear that should the state decide to proceed with the closing of the Georgia Retardation Center and the Southwest

Developmental Center at Bainbridge the transition must be planned carefully to minimize the risks of the negative impacts of relocation, often called transfer trauma. Careful planning is particularly important in the case of medically-involved persons (e.g., the approximately 94 individuals currently living in SNF beds within the GRC facility) who, due to their health problems, present an additional risk. In terms of resident preparation for relocation at both of the facilities there are several issues that should be considered to minimize the risks of transfer trauma.

a. It is Important to Maintain as Much Stability as Possible for Individuals During the Closure Process

Essentially, this means that clients and staff should be kept together as much as possible internally. Because transfer trauma can occur when moving individuals from one building to another as easily as from the institution to the community, it is important that clients *not* be moved from unit to unit during the phasedown process. The closure should be coordinated to minimize client movement, closing buildings as clients move to the community. The maintenance of client groupings is critical to the success of this process. Equally important is the stability of the staff with whom the clients are familiar. Staff transfers should be minimized whenever possible.

b. A Relocation Process Should be Established so that the Relocation of Individuals is Managed Efficiently and Consistently Both Within and Between the Two Institutions

Resident relocation teams, coordinated by the deputy project directors should be organized in each of the two institutions. These teams comprised of a primary care person from the facility and a case or cluster managers would oversee the relocation process for each individual at GRC and Bainbridge. Prior to placement, the local case manager should meet the individual, and his/her parent/guardian, to discuss the placement process with them, including their rights and responsibilities. A notice should be sent to the individual and his/her parents/guardian, informing them that they will be given full opportunity for participation in the development of the Individual Habilitation Plan for transition to community services. In the absence of a parent/guardian or at the request of the parent/guardian or at the request of the parent/guardian, the case manager should request an advocate. The case manager in cooperation with the direct care person who knows the individual best should complete an individual assessment of adaptive behavior skills and maladaptive behaviors, to begin to assess the individual's needs for service. For those individuals with overriding medical concerns, an assessment of those concerns should be provided by the individual's primary care physicians at GRC and Bainbridge. The case manager would then schedule an interdisciplinary team meeting at the facility. The meeting would include but not be limited to:

1) The individual receiving services;

2) The parent/guardian and/or advocate;

3) The county case manager or cluster manager;

4) The current facility social worker;

5) Representative from the community residential provider agency;

6) Representative from the day program provider agency;

7) Direct care staff from the institution;

8) Therapy staff from the institution as the case manager deems appropriate (speech, OT/PT, etc.);

9) For those individuals with overriding medical concerns, there should be a physician from the institution, as well as the community physician who will be providing services to the client; and

10) For those individuals with overriding behavioral concerns, there should be a behavioral expert from the institution and the community present.

The team members should come to the meeting with their own assessments of the individual, and should be prepared to review all individual assessments with the team. Based on the individual assessments provided by each of the professionals, as well as the individual assessment performed by the case manager, the team should begin to develop an individual habilitation plan (IHP) for the individual. The IHP should follow a standardized format (goals, objectives, timelines, persons responsible, services, etc.). Ultimately, it should be the responsibility of the case manager to prepare the final IHP document.

Also during this meeting, the team should establish a placement plan for each individual. This plan should include all plans for preplacement visits, site requirements (necessary location, adaptations, etc.) staffing, health and safety precautions.

- ***preplacement visits*** - the purpose of these visits is to acquaint the person with the proposed residence, day program, staff, housemates, co-workers and the community. This is important even for those individuals with the most severe medical needs if it is deemed possible and appropriate by the sending and receiving physicians. Whenever possible, staff from the institution should accompany the individual on preplacement visits. The preplacement visits will give the individual an opportunity to demonstrate his/her skills in a different environment, and will allow staff of the receiving of the receiving home an opportunity to assess baseline behavior and learning skills. The team should decide how many preplacement visits should occur as well as the duration of each visit (a meal, a day, a weekend, etc.). The case manager should insure that the community provider has all relevant information about the individual before any visits occur. S/he should also plan for emergency medical coverage (and behavioral back-up where necessary) for the duration of each visit. The provider should report personal observations of the visit to the case manager. The case manager should also report personal observations of the visits and share them with the team.

- ***site requirements*** - this is especially critical for those individuals with overriding medical needs. The physicians (both sending and receiving) should determine how proximate an individual needs to be to an emergency room or to some acute care facility. Once this has been determined, it is the provider's responsibility to choose a site that meets the physicians recommendations with regard to proximity to medical services. The team should also be consulted for any other overriding needs in terms of location. Some families request that their family members live close to them. This request should be honored whenever possible. There may also be a need for adaptations to the home once it has been selected. Adaptations should be made as the result of recommendations by appropriate professionals (physicians, physical therapists, etc,).

- ***staffing*** - The team should decide, based on the needs of the individuals, what the staffing patterns in the home should be. For some individuals, it will be important to try and retain as much of the direct care staff as possible from the institution.

If the team recommends this, and the staff are willing, every effort should be made to transfer institutional staff to community programs. In addition to direct care staff, recommendations should be made for other professional staff. For individuals with overriding medical needs, there must be appropriate back-up planned for well in advance of the individual's relocation. For those individuals with overriding behavioral needs, there is a need for behavioral back-up as well.

- *health and safety precautions* - This may include anything from traffic considerations (for individuals who may wander away) to the choice of a house with no stairs for individuals who are ambulatory but who experience severe cardiac problems. These types of recommendations should by made by the team. Another area that is often ignored during this process is the individual's choice of roommates. In any case where an individual expresses a preference of roommates, and the potential roommate(s) agree, every effort should be made to keep friends together. In some cases this may involve individuals for whom more than one county is responsible. It is possible and important to make whatever financial arrangements are necessary to insure that friendship groups are maintained whenever possible.

Once the team meeting has been completed, it is the responsibility of the case manager to write the formal plan. Once the plan has been written, each member of the team should have the opportunity to sign the plan stating that they either agree or disagree with the provision of the IHP. If any team member disagrees including the family, s/he should state their concerns in writing. A procedure should be in place for mediating such disagreements. In other states an impartial hearing

VI. IMPLEMENTATION: ELEMENTS AND TIMING

Previous discussion identifies the range of activities that must be undertaken in order to make the phase down of GRC and Bainbridge a feasible undertaking. There is, however, one more critical element that must be considered in determining the feasibility of developing community based systems of services as alternatives to GRC and Bainbridge -- timing. As can be deduced from the multiple tasks outlined in this study, the process of deinstitutionalization and community service development is complex and requires careful planning, scheduling and coordination.

This section of the study report briefly discusses five phases of activity that must be completed in order to phase down the GRC and Bainbridge programs and develop alternative community based systems of service for GRC and Bainbridge residents and for other populations of concern. Included in parentheses is an estimate of the minimum amount of time required to complete each phase.

A. Phase One -- Strategic Planning and Preparing System Design Specifications (months 1-5)

This first phase of implementation involves making strategic decisions regarding the development of community-based alternatives to GRC and Bainbridge, and developing budget estimates for the first year of the phase down effort. Some of the decisions that must be made include the extent to which private sector involvement in service provision should be encouraged and controlled, the appropriateness of and key features of a capitation scheme of fund allocation, needed improvements in quality assurance standards and procedures, the funding strategy to be employed, client and family protections to be adopted, and the organization of the implementation management team. These key policy decisions will shape the content and objectives of the implementation plans and will also determine the necessity for specific legislative and regulatory change.

Finally, during this phase, state staff must prepare a budget request to cover the major implementation activities involved in the first year of the project including the employment of a transition management team. The plan and budget request should also provide for an independent evaluation of the transition process and outcomes. The evaluation will serve to assure all interests that the important issues of concern will be subject to professional, impartial and thorough review.

B. Phase Two -- Legislative Actions (months 2-6)

This phase involves the drafting of that legislation that must be enacted consistent with the strategic planning decisions made in the first phase. The principal legislative actions would include:

- the drafting of a statewide zoning bill to facilitate the siting of residential and day services in Georgia communities;

- the establishment of a revolving loan fund to underwrite these startup costs of community services;

- the drafting of a receivership statute whereby the state would step in to administer services to individuals in the case of provider bankruptcy, or inability to provide services in compliance with established standards;

- provisions for the use of the funds realized from the sale of the GRC and/or Bainbridge campuses.

C. Phase Three -- Implementation Planning and Management, State Level Staffing and Plan Preparation (months 8-12), Local Level Staffing and Plan Preparation (months 12-48), Monitoring and Coordination (months 12-18)

This phase involves the recruitment of a management team to plan and coordinate the implementation of the GRC and Bainbridge phasedowns and the development of community based alternatives. It involves the appointment of a steering committee representating families, consumers, employees, service providers and managers; the hiring of resource developers and cluster managers to expedite the development of community based services and the detailing of DHR staff to carry out key transition activities. It further involves preparing a detailed implementation plan, budget projections pegged to the phasdown schedule, and procedures for maintaining the implementation process. Finally, it involves the development and submission of the Title XIX waiver

D. Phase Four -- System Development (months 10-18)

This phase involves the actual development of the many system changes recommended in this report. These systems must be in place prior to the start-up of all but the ICF-MR services. The successful start-up and operation of the ICF-MR's are not dependent on these system changes.

- the development of guidelines to assess local service area capacity to carry out the level of resource development necessary to meet the needs of GRC and Bainbridge residents who will be returning to that community (?)
- The development of a program to foster the development of specialized family care arrangements.
- The development of procedures for the alternative community placement of technology dependent children many currently served at GRC including the feasibility of their support in the natural home.
- The development and implementation of recommended improvements in the quality assurance system procedures and standards.
- The development of an "Request for Proposal" process designed to foster the development of programs identified in the implementation plan.
- The development of uniform contracting formats to assist local health boards in the purchase of private provider services.
- The review and revision of fee schedules, and budget, expenditure and audit procedures consistent with the capitation scheme proposed. The development of a capitation scheme for fund allocation.
- The development of systems to support the recruitment and training and retrainining of required program staff.
- The development of procedures to be followed in individual client transition planning and outplacement.

E. Phase Five -- Program Start-Up and Operation (months 18-36)

This phase involves the start-up and operation of needed programs, the implementation of the systems developed in Phase Four, and the outplacment and follow-up of the members of the target populations. It also involves the the evaluation of the processes and outcomes associated with this undertaking.

APPENDIX A: REFERENCES

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APPENDIX B:

INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP)

APPENDIX E:

STANDARDS FOR SOUTH CAROLINA FACILITIES SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES

Revised 5/13/87

STANDARDS FOR DEVELOPMENTAL SERVICES FOR PERSONS WITH HANDICAPS AND DISABILITIES

The following standards apply to all state and local providers of developmental services to persons with handicapping and disabling conditions.

*NOTE: Indicators marked with an asterisk are Required indicators. Those marked with two asterisks are Diagnostic and Research Type (DART) indicators. All others are Enhancement indicators.

+NOTE: see Definitions at end of document.

1. HUMAN RESOURCES STANDARDS

Developmental services personnel covered by these standards include both volunteers and paid employees, including service provider agencies' administrative and direct service staff.

STANDARD 1.1: The personnel of the agency+ shall be appropriately qualified to carry out the agency's program of services.

Indicators:

1. The agency director has a bachelor's degree in a human services field, administration or a related field and two years of experience in administration or supervision in a human services field; or a master's degree in a human service or related field and one year of experience.

*2. 100 percent of persons offering professional services have applicable licensure, certification or registration for offering these professional services+, or are in the process, as defined by the appropriate body.

3. 100 percent of persons providing professional or supervisory services have a bachelor's degree and one year of experience working with handicapped and developmentally disabled persons, or a master's degree in either child development, developmental disabilities, vocational rehabilitation, social work, or other area relevant to their job responsibilities.

*4. 100 percent of direct care staff have a high school diploma or GED and appropriate certifcation in the area in which they are working, and are over age 18.

5. 100 percent of the direct care workers have completed the basic human services training or orientation+, plus the agency's job specific training, within three months after hire.

__Discussion__: The general consensus in the field is that personnel who work with adults and children with handicaps or disabilities need basic human services training as well as training specific to their service assignments. All indicators are currently set at minimal levels; they will be made more specific as the QA system provides information about the relationship between staff qualifications and the quality of service delivery. The state may wish to consider certification procedures for all direct care staff.

3. CLIENT STANDARDS

Clients covered by these standards are defined in the philosophy statements for Special Services to Handicapped and Disabled Adults and Developmental Services for Handicapped and Disabled Children. Included are clients and their families or guardians and other persons significant to the client's daily living.

STANDARD 3.1:. The agency shall make available its services without discrimination based upon race, color, religion, national origin, marital status, sex, sexual preference, age, or handicapping or disabling condition.

Indicators:

**1. The agency conducts a formal needs assessment+ in its geographic target community+, or has access to such information collected by other human services agencies.

**2. The clientele for any given agency service includes members of all racial, ethnic or cultural groups in the community which have been identified in the formal needs assessment as needing such a service.

‡Discussion: Discrimination can occur deliberately, when an agency specifically excludes certain clients from its services, or inadvertently, when an agency is not well enough informed about the needs of people in its community.

STANDARD 3.2: The agency shall assure that the human and civil rights of persons with disabling and handicapping conditions are protected, acknowledged and upheld.

Indicators:

*1. The agency has a written statement of policies and procedures concerning the exercise and protection of individual rights, including personal advocacy services.

*2. The agency complies with federal and state confidentiality laws and regulations.

*3. The agency has documented evidence that an effort has been made to explain to all clients, family, or other relevant persons, the conditions of the particular services they are receiving and their specific rights and responsibilities.

*4. Any application for service includes a consent-to-treatment form signed by the client, a parent or guardian.

*5. When modification or restriction of an individual's rights is under consideration, the rights to be modified are specifically explained to the individual, the family or other relevant persons and they are advised of the process involved in modifying such rights, and any modification or restriction is documented as being specific to the individual's ability to exercise that right.

*6. The agency has in place and documents that clients, family, or other relevant persons have been informed of formal written procedures to lodge complaints or appeals+ when decisions concerning them or services provided them are considered unsatisfactory; the written appeals procedures are conspicuously posted.

Discussion: *Frequently the human and civil rights of persons with disabilities are denied or neglected. Persons with disabilities should be considered capable of exercising the same human and civil rights enjoyed by other citizens. Individuals with developmental disabilities and other handicaps should be taught insofar as possible to represent their own interests and rights.*

STANDARD 3.3: The agency shall consider the opinions, preferences and views of the client and guardian or family members in all aspects of agency planning.

Indicators:

1. Communication mechanisms are documented and implemented that provide specific opportunities for clients and their families to share opinions and concerns about agency structure and programming.

2. Minutes from administrative meetings reflect the inclusion of client points of view.

**3. At least annually, the agency gathers information from clients regarding their satisfaction with agency procedures.

4. The agency has a board of directors which includes persons with disabilities, their family members, and/or advocates.

Discussion: *Agencies serving persons with disabilities and their families can maximize the responsiveness of their services by being attentive to the expressed preferences of clients. By giving clients a greater opportunity to participate, self-esteem and choice-making skills are enhanced.*

THE FOLLOWING STANDARDS APPLY ONLY TO ADULT CLIENTS:

STANDARD 3.4: Adult clients shall receive appropriate compensation for work performed.

Indicators:

*1. There is documented evidence of each individual's amount or degree of production and earning rate per pay period.

*2. Clients are paid according to work performed which is documented in the written statements of earnings that accompany each check.

*3. All clients are paid the applicable Labor Department certificate minimums and wages as required by law.

Discussion: *All citizens, including persons with disabilities, have legal and civil rights that must be upheld and protected in work-related activities. Past infringement of such rights, including the use of peonage in institutions, emphasize the importance of this standard.*

STANDARD 3.5: Adult clients shall increase their integration in the community.

Indicators:

1. Each client participates in a variety of activities+ on his/her own or as part of a small group.

2. Individual client plans reflect community integration objectives+.

__Discussion:__ *Merely attending a day program in the community is not tantamount to being integrated in the community. Service providers need to take specific steps to ensure that clients have both the skills and the opportunities to participate in the life of the community at large. Community integration is a basic outcome of services to the handicapped.*

STANDARD 3.6: Adults shall form friendships and engage in social relationships.

Indicators:

1. Opportunities are provided for clients to form and carry on friendships.

**2. At least 70 percent of clients and/or their families express satisfaction with the quality of their social contacts when responding to agency queries.

3. Individual client plans include provisions for sustaining and supporting friendships.

__Discussion:__ *To enable persons to enhance the quality of their lives and to ensure that they are capable of entering into normal social relationships, providers must encourage such interactions within their programs, while inculcating the skills needed to engage in such relationships outside the program.*

STANDARD 3.7: The agency shall maximize opportunities for adult clients to achieve independence.

Indicators:

*1. Adult clients are taught skills to lessen dependence, among which may be: community living skills, self-care skills, socialization skills, communiction skills, vocational skills, educational skills, behavioral needs, and motor development.

*2. Individual program plans reflect progress toward increasing independence by setting timetables and evaluating achievement of targeted objectives.

3. Within the past year, 80 percent of clients have achieved the objectives targeted in the areas identified in 3.7.1.

__Discussion:__ *The ultimate goal of any agency providing services to adults with disabilities and handicaps is to totally eliminate the client's need for services. To achieve this goal, service providers must: (1) constantly assess the skills of clients and identify where supportive services can be reduced or redirected, and (2) examine the interactions of the client with his/her work and neighborhood environments to pinpoint areas where the client can lessen dependence by using available resources more creatively. In order to give persons with* *disabilities the capacity to participate in the life of the community, providers must assist clients to acquire those skills that are most relevant to independent functioning. Several scales currently exist that make it possible to chart growth in each of the skill domains.*

STANDARD 3.8: The agency shall provide opportunities for clients that lead to competitive employment.

Indicators:

*1. The agency tailors its training program to the particular skills needed for clients to compete in the local job market.

*2. Agency personnel know of job opportunities in the local area.

*3. Individual objectives include provisions for movement into more integrated and competitive work settings.

4. In the past year, at least 5 percent of clients in the program have moved into more work-oriented and/or competitive settings.

Discussion: All adults with disabilities and handicaps should have the opportunities and skills necessary to compete for jobs in the labor market. An important way to increase these opportunities and to enhance skills is to work with clients in on-the-job training programs. Implementing supported work and transitional employment models overcomes the isolation and segregation that result from conventional work activity, sheltered workshop and day habilitation programs. In order to stimulate more dynamic work opportunities and to ensure that clients reach their maximum work potential, providers should build transitional employment and supported work models into their current programs.

THE FOLLOWING STANDARDS APPLY ONLY TO CHILD CLIENTS:

STANDARD 3.9: The agency shall maximize opportunities for child clients to increase independent functioning.

Indicators:

*1. Children are taught skills to lessen dependence among which may be: sensorimotor skills, gross motor, fine motor, communication and language, social interaction/play, self-help skills, cognitive functioning, and emotional/behavioral skills.

*2. Individual program plans reflect progress toward increasing independent functioning by setting timetables and evaluating achievement of targeted objectives.

3. Within the past year, 80 percent of children have achieved the objectives targeted in the areas identified in 3.9.1.

Discussion: Tracking the progress of clients in achieving targeted objectives is the keystone of an effective intervention program.

STANDARD 3.10: As a result of agency services to children, families demonstrate improved functioning.

Indicators:

*1. The agency makes available to families descriptive material about child disabilities and appropriate training and technical assistance based on the nature of the child's disabling condition.

**2. The agency at least annually elicits information from families to assess their functioning level and to determine their satisfaction with information and training provided.

*3. At least 50 percent of families demonstrate a reduction of family stress and improved family functioning, after one year of service.

**4. At least 50 percent of families demonstrate an increased sense of control and self-esteem, after one year of service.

**5. At least 80 percent of families demonstrate increased knowledge regarding their child's potential, after one year of service.

Discussion: *A major objective of providers serving children with disabilities and their families should be to educate families regarding the nature of their child's disability and to assist families to use such information in caring for the child. Lessening the mystery surrounding the child's disability should substantially reduce the family's anxiety.*

4. SERVICES STANDARDS

Specialized services for adults covered by these standards include sheltered workshops, work activity centers, and pre-vocational and skills development centers. Developmental services for children with handicaps and disabilities and their families include pre-adjustment counseling, early intervention, and assessment and evaluation services.

STANDARD 4.1: The agency shall ensure inter-agency collaboration, as necessary to meet the service needs of its clientele.

Indicators:

1. To facilitate the provision of services through the referral process, the agency has written cooperative agreements with other service providers or has written service agreements promulgated by a higher administrative level; these shall be reviewed at least annually and revised as necessary.

*2. Each client has an identified service manager coordinating services to the client.

*3. For clients in day services, direct service staff are included in all treatment planning and annual reviews.

*4. Individual client plans indicate participation of all relevant agencies and/or individuals.

APPENDIX F:

PROJECTED SERVICE REQUIREMENTS AND COSTS BY CLIENT LEVEL OF FUNCTIONING AND TYPE OF SERVICE

TABLE F.1
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, AGES 0-5
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	ALL(1-10) INDIV #	ALL(1-10) TOTAL COST	1 MED/PHYS OVRDG SKL IV INDIV #	UNIT #	UNIT COST	TOTAL COST	2 BEH-OVRDG SKL IV INDIV #	UNIT #	UNIT COST	TOTAL COST	3 CHRONIC&OTHER SKL IV INDIV #	UNIT #	UNIT COST	TOTAL COST	4 BEH-OVRDG SKL III INDIV #	UNIT #	UNIT COST	TOTAL COST	5 CHRONIC SKL III INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	12	$1,488	7	1	$124	$868	0	1	$124	$0	5	1	$124	$620	0	1	$124	$0	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	12	$17,220	7	41	$35	$10,045	0	41	$35	$0	5	41	$35	$7,175	0	41	$35	$0	0	41	$35	$0
CLUSTER MANAGEMENT	Client	12	$18,000	7	1	$1,500	$10,500	0	1	$1,500	$0	5	1	$1,500	$7,500	0	1	$1,500	$0	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	7	$516,110	7	365	$202	$516,110	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	4	$152,023	0	365	$159	$0	0	365	$172	$0	4	365	$119	$152,023	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	1	$5,475	0	365	$35	$0	0	365	$40	$0	1	365	$30	$5,475	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE IIIFAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE II FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	1	$3,699	0	365	$10	$0	0	365	$10	$0	1	365	$10	$3,699	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SCH	Days	4	$26,040	0	240	$38	$0	0	240	$36	$0	4	240	$31	$26,040	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SCH	Days	1	$3,720	0	240	$38	$0	0	240	$36	$0	1	240	$31	$3,720	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	0	$0	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	1	$9,600	0	600	$16	$0	0	600	$16	$0	1	600	$16	$9,600	0	700	$16	$0	0	600	$16	$0
SPCH & HRNG THERAPY	Hours	2	$4,470	0	42	$30	$0	0	84	$33	$0	2	70	$33	$4,470	0	129	$33	$0	0	113	$33	$0
PHYSICAL THERAPY	Hours	2	$2,481	0	70	$30	$0	0	47	$33	$0	2	47	$33	$2,481	0	47	$33	$0	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	16	$30	$0	0	16	$25	$0	0	32	$25	$0	0	43	$25	$0	0	32	$25	$0
CRISES INTERVENTION	Client	0	$0	0	1	$136	$0	0	1	$136	$0	0	1	$136	$0	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	1	$9,200	0	131	$35	$0	0	394	$33	$0	1	263	$35	$9,200	0	394	$35	$0	0	219	$35	$0
PSYCHO- THERAPY	Hours	0	$38	0	24	$8	$0	0	72	$8	$0	0	24	$8	$38	0	72	$8	$0	0	32	$8	$0
PERSONAL CARE SVCS	Visit	1	$11,400	0	250	$57	$0	0	250	$57	$0	1	200	$57	$11,400	0	150	$57	$0	0	100	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	5	$1,500	0	1	$600	$0	0	1	$400	$0	5	1	$300	$1,500	0	1	$300	$0	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	12	$96,000	7	1	$8,000	$56,000	0	1	$8,000	$0	5	1	$8,000	$40,000	0	1	$8,000	$0	0	1	$8,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	12	$4,660	7	1.50	$355	$3,728	0	0.00	$0	$0	5	0.89	$210	$932	0	0.00	$0	$0	0	0.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	1	$1,500	0	30	$50	$0	0	30	$50	$0	1	30	$50	$1,500	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.1 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, AGES 0-5
WAIVER STRATEGY

			ALL	6 OTHER SKL				7 BEH-OVRDG SKL				8 CHRONIC SKL				9 OTHER SKL				10 OTHER SKL			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	12	$1,488	0	1	$124	$0	0	1	$124	$0	0	1	$124	$0	0	1	$124	$0	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	12	$17,220	0	41	$35	$0	0	41	$35	$0	0	41	$35	$0	0	41	$35	$0	0	41	$35	$0
CLUSTER MANAGEMENT	Client	12	$18,000	0	1	$1,500	$0	0	1	$1,500	$0	0	1	$1,500	$0	0	1	$1,500	$0	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	7	$516,110	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	4	$152,023	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME II MOD SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	1	$5,475	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE I FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	1	$3,699	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	4	$26,040	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	1	$3,720	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	0	$0	0	240	$24	$0	0	240	$30	$0	0	240	$22	$0	0	240	$19	$0	0	240	$17	$0
HOME-BASED TRAINING	Hours	1	$9,600	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0	0	500	$16	$0	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	2	$4,470	0	113	$33	$0	0	164	$33	$0	0	141	$33	$0	0	152	$33	$0	0	176	$33	$0
PHYSICAL THERAPY	Hours	2	$2,401	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	28	$25	$0	0	80	$25	$0	0	37	$25	$0	0	35	$25	$0	0	41	$25	$0
CRISES INTERVENTION	Client	0	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	1	$9,200	0	263	$35	$0	0	394	$35	$0	0	197	$35	$0	0	263	$35	$0	0	329	$35	$0
PSYCHO- THERAPY	Hours	0	$38	0	40	$8	$0	0	72	$8	$0	0	36	$8	$0	0	48	$8	$0	0	60	$8	$0
PERSONAL CARE SVCS	Visit	1	$11,400	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	3	$1,300	0	1	$150	$0	0	1	$200	$0	0	1	$125	$0	0	1	$100	$0	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
ACUTE CARE	Client	12	$96,000	0	1	$8,000	$0	0	1	$8,000	$0	0	1	$8,000	$0	0	1	$8,000	$0	0	1	$8,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	12	$4,660	0	10.00	$0	$0	0	10.00	$0	$0	0	10.00	$0	$0	0	10.00	$0	$0	0	10.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	1	$1,500	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$59	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0

TABLE F.2
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, AGES 6-21
WAIVER STRATEGY

YEAR 0

		ALL(1-10)		1 MED/PHYS OVRDG SKL IV				2 BEH-OVRDG SKL IV				3 CHRONIC&OTHER SKL IV				4 BEH-OVRDG SKL III				5 CHRONIC SKL III			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	127	$15,740	34	1	$124	$4,216	2	1	$124	$248	77	1	$124	$9,548	1	1	$124	$124	10	1	$124	$1,240
INDIV PLNG & MONITORING	Hours	127	$182,245	34	41	$35	$48,790	2	41	$35	$2,870	77	41	$35	$110,495	1	41	$35	$1,435	10	41	$35	$14,350
CLUSTER MANAGEMENT	Client	127	$190,500	34	1	$1,500	$51,000	2	1	$1,500	$3,000	77	1	$1,500	$115,500	1	1	$1,500	$1,500	10	1	$1,500	$15,000
ICF-MR IVA MEDCL SUPV	Days	34	$2,506,820	34	365	$202	$2,506,820	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	2	$162,060	0	365	$202	$0	2	365	$222	$162,060	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	2	$116,070	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	1	365	$172	$62,780	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	63	$2,685,816	0	365	$159	$0	0	365	$172	$0	62	365	$119	$2,675,396	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	9	$347,663	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	8	365	$109	$318,280
GRP HOME I MIN SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	8	$84,315	0	365	$35	$0	0	365	$40	$0	8	365	$30	$84,315	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$2,190	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$2,190
SPEC CARE IIIFAMILY	Days	1	$10,585	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$8,760
SPEC CARE II FAMILY	Days	0	$1,460	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	0	$1,460	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	9	$32,910	0	365	$10	$0	0	365	$10	$0	8	365	$10	$20,400	0	365	$10	$0	1	365	$10	$3,699
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	0	$900	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	18	$172,320	0	600	$16	$0	0	600	$16	$0	15	600	$16	$147,840	0	700	$16	$0	2	600	$16	$19,200
SPCH & HRNG THERAPY	Hours	0	$0	0	42	$30	$0	0	84	$33	$0	0	70	$33	$0	0	129	$33	$0	0	113	$33	$0
PHYSICAL THERAPY	Hours	0	$0	0	70	$30	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	16	$30	$0	0	16	$25	$0	0	32	$25	$0	0	43	$25	$0	0	32	$25	$0
CRISES INTERVENTION	Client	8	$1,273	0	1	$156	$0	0	1	$156	$50	6	1	$156	$961	0	1	$156	$31	1	1	$156	$172
BEHAVIORAL CONSULTATION	Hours	21	$197,493	0	131	$35	$0	0	394	$35	$0	15	263	$35	$141,600	1	394	$35	$13,800	3	219	$35	$24,333
PSYCHO- THERAPY	Hours	4	$768	0	24	$8	$0	0	72	$8	$0	3	24	$8	$591	0	72	$8	$58	0	32	$8	$31
PERSONAL CARE SVCS	Visit	9	$94,193	0	250	$57	$0	0	250	$57	$0	8	200	$57	$87,780	0	150	$57	$0	1	100	$57	$5,700
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	91	$25,850	0	1	$600	$0	0	1	$400	$0	77	1	$300	$23,100	1	1	$300	$300	10	1	$200	$2,000
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	127	$254,000	34	1	$2,000	$68,000	2	1	$2,000	$4,000	77	1	$2,000	$154,000	1	1	$2,000	$2,000	10	1	$2,000	$20,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	127	$42,426	34	1.50	$355	$18,100	2	1.63	$385	$1,250	77	1.00	$237	$18,226	1	1.63	$385	$623	10	0.92	$218	$2,003
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	8	$11,550	0	30	$50	$0	0	30	$50	$0	8	30	$50	$11,550	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	1	$1,176	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	1	28	$40	$1,120
LEVEL II RESPITE	Days	0	$63	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$26	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.2 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, AGES 6-21
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL		6 OTHER SKL				7 BEH-DVRBG SKL				8 CHRONIC SKL				9 OTHER SKL				10 OTHER SKL			
		INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	127	$15,748	1	1	$124	$124	1	1	$124	$124	0	1	$124	$0	1	1	$124	$124	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	127	$182,245	1	41	$35	$1,435	1	41	$35	$1,435	0	41	$35	$0	1	41	$35	$1,435	0	41	$35	$0
CLUSTER MANAGEMENT	Client	127	$190,500	1	1	$1,500	$1,500	1	1	$1,500	$1,500	0	1	$1,500	$0	1	1	$1,500	$1,500	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	34	$2,306,820	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	2	$162,060	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	2	$116,070	0	365	$95	$0	1	365	$146	$53,290	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	63	$2,603,016	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	1	365	$28	$10,220	0	365	$24	$0
GRP HOME II MOD SUPV	Days	9	$347,663	1	365	$95	$24,272	0	365	$146	$0	0	365	$57	$0	1	365	$28	$5,110	0	365	$24	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	8	$84,315	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	0	$2,190	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	1	$10,585	0	365	$25	$1,825	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	0	$1,460	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$1,460	0	365	$15	$0
SPEC CARE I FAMILY	Days	0	$1,460	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$1,460	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	9	$32,910	0	365	$10	$370	0	365	$10	$0	0	365	$10	$0	0	365	$10	$370	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	0	$900	0	240	$24	$0	0	240	$30	$0	0	240	$22	$0	0	240	$19	$900	0	240	$17	$0
HOME-BASED TRAINING	Hours	18	$172,320	0	600	$16	$2,800	0	700	$16	$0	0	600	$16	$0	0	500	$16	$2,400	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	0	$0	0	113	$33	$0	0	164	$33	$0	0	141	$33	$0	0	152	$33	$0	0	176	$33	$0
PHYSICAL THERAPY	Hours	0	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	28	$25	$0	0	80	$25	$0	0	37	$25	$0	0	35	$25	$0	0	41	$25	$0
CRISES INTERVENTION	Client	8	$1,273	0	1	$156	$5	0	1	$156	$51	0	1	$156	$0	0	1	$156	$3	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	21	$197,493	0	263	$35	$2,300	1	394	$35	$13,800	0	197	$35	$0	0	263	$35	$1,300	0	329	$35	$0
PSYCHO- THERAPY	Hours	4	$768	0	40	$8	$6	0	72	$8	$58	0	36	$8	$0	0	48	$8	$4	0	60	$8	$0
PERSONAL CARE SVCS	Visit	9	$94,193	0	75	$57	$420	0	150	$57	$0	0	75	$57	$0	0	50	$57	$285	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	91	$25,030	1	1	$150	$150	1	1	$200	$200	0	1	$125	$0	1	1	$100	$100	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
ACUTE CARE	Client	127	$254,000	1	1	$2,000	$2,000	1	1	$2,000	$2,000	0	1	$2,000	$0	1	1	$2,000	$2,000	0	1	$2,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	127	$42,426	1	10.83	$196	$163	1	11.38	$325	$448	0	10.00	$0	$0	1	12.60	$616	$1,603	0	10.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	8	$11,550	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	1	$1,176	0	20	$40	$56	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0
LEVEL II RESPITE	Days	0	$63	0	21	$30	$32	0	21	$30	$0	0	21	$30	$0	0	21	$30	$32	0	21	$30	$0
LEVEL I RESPITE	Days	0	$26	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$26	0	21	$25	$0

TABLE F.3
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, AGES 22+
WAIVER STRATEGY

YEAR 0

		ALL(1-10)		1 MED/PHYS OVRDG SKLIV				2 BEH-OVRDG SKLIV				3 CHRONIC&OTHER SKLIV				4 BEH-OVRDG SKLIII				5 CHRONIC SKLIII			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	300	$37,200	56	1	$124	$6,944	8	1	$124	$992	171	1	$124	$21,204	2	1	$124	$248	28	1	$124	$3,472
INDIV PLNG & MONITORING	Hours	300	$430,500	56	41	$35	$80,360	8	41	$35	$11,480	171	41	$35	$245,385	2	41	$35	$2,870	28	41	$35	$40,180
CLUSTER MANAGEMENT	Client	300	$450,000	56	1	$1,500	$84,000	8	1	$1,500	$12,000	171	1	$1,500	$256,500	2	1	$1,500	$3,000	28	1	$1,500	$42,000
ICF-MR IVA MEDCL SUPV	Days	56	$4,128,880	56	365	$202	$4,128,880	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	8	$648,240	0	365	$202	$0	8	365	$222	$648,240	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	3	$170,850	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	2	365	$172	$125,560	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	142	$5,993,000	0	365	$159	$0	0	365	$172	$0	137	365	$119	$5,941,900	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	41	$1,546,342	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	22	365	$109	$891,184
GRP HOME I MIN SUPV	Days	4	$50,316	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	34	$374,490	0	365	$35	$0	0	365	$40	$0	34	365	$30	$374,490	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	1	$12,264	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$12,264
SPEC CARE IIIFAMILY	Days	13	$122,969	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	4	365	$30	$49,056
SPEC CARE II FAMILY	Days	2	$18,250	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	1	$7,300	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SCL	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SCL	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	158	$1,490,272	0	240	$43	$0	0	240	$50	$0	137	240	$40	$1,313,280	2	240	$47	$22,560	14	240	$36	$120,960
SHELTERED WORK	Days	30	$243,000	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	14	240	$36	$120,960
INTEGRATED ADULT SVCS	Days	12	$86,196	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	2	$7,713	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	600	$16	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0
SPCH & HRNG THERAPY	Hours	88	$239,447	0	42	$30	$0	0	84	$33	$0	66	70	$33	$152,073	1	129	$33	$2,900	10	113	$33	$37,130
PHYSICAL THERAPY	Hours	70	$121,218	0	70	$30	$0	0	47	$33	$0	55	47	$33	$84,044	0	47	$33	$352	12	47	$33	$18,234
OCCUPATIONAL THERAPY	Hours	125	$99,694	0	16	$30	$0	0	16	$25	$0	89	32	$25	$71,060	1	43	$25	$1,339	18	32	$25	$14,344
CRISES INTERVENTION	Client	20	$3,111	0	1	$156	$0	1	1	$156	$200	14	1	$156	$2,134	0	1	$156	$62	3	1	$156	$480
BEHAVIORAL CONSULTATION	Hours	54	$496,300	0	131	$35	$0	0	394	$35	$0	34	263	$35	$314,640	2	394	$35	$27,600	9	219	$35	$68,693
PSYCHO- THERAPY	Hours	8	$1,833	0	24	$8	$0	0	72	$8	$0	7	24	$8	$1,313	0	72	$8	$115	1	32	$8	$143
PERSONAL CARE SVCS	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	236	$62,500	0	1	$600	$0	0	1	$400	$0	171	1	$300	$51,300	2	1	$300	$600	28	1	$200	$5,600
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	300	$150,000	56	1	$500	$28,000	8	1	$500	$4,000	171	1	$500	$85,500	2	1	$500	$1,000	28	1	$500	$14,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	300	$207,881	56	1.50	$355	$29,824	8	1.63	$385	$5,000	171	1.32	$312	$70,525	2	######	$2,539	$34,453	28	1.52	$360	$15,312
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.3 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, AGES 22+
WAIVER STRATEGY

		ALL		6 OTHER SKL				7 BEH-OVRDG SKL				8 CHRONIC SKL				9 OTHER SKL				10 OTHER SKL			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	300	$37,200	27	1	$124	$3,348	1	1	$124	$124	2	1	$124	$248	5	1	$124	$620	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	300	$430,500	27	41	$35	$38,745	1	41	$35	$1,435	2	41	$35	$2,870	5	41	$35	$7,175	0	41	$35	$0
CLUSTER MANAGEMENT	Client	300	$450,000	27	1	$1,500	$40,500	1	1	$1,500	$1,500	2	1	$1,500	$3,000	5	1	$1,500	$7,500	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	56	$4,120,000	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	8	$648,240	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	3	$178,850	0	365	$95	$0	1	365	$146	$53,290	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	142	$5,993,000	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	5	365	$28	$51,100	0	365	$24	$0
GRP HOME II MOD SUPV	Days	41	$1,346,342	19	365	$95	$655,350	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME I MIN SUPV	Days	4	$30,516	0	365	$95	$0	0	365	$146	$0	1	365	$57	$24,966	3	365	$28	$25,550	0	365	$24	$0
SPEC CARE IV FAMILY	Days	34	$374,490	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	1	$12,264	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	13	$122,969	8	365	$25	$73,913	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	2	$18,250	0	365	$25	$0	0	365	$30	$0	1	365	$25	$7,300	2	365	$20	$10,950	0	365	$15	$0
SPEC CARE I FAMILY	Days	1	$7,300	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	1	365	$20	$7,300	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	158	$1,498,272	5	240	$32	$41,472	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	30	$243,000	14	240	$32	$103,680	1	240	$40	$7,680	1	240	$29	$5,368	1	240	$25	$6,000	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	12	$86,196	8	240	$32	$62,208	0	240	$40	$1,920	1	240	$29	$5,368	3	240	$25	$16,500	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	2	$7,713	0	240	$24	$0	0	240	$30	$0	0	240	$22	$2,008	1	240	$19	$5,625	0	240	$17	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0	0	500	$16	$0	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	88	$239,447	9	113	$33	$33,705	0	164	$33	$2,200	0	141	$33	$2,276	2	132	$33	$8,276	0	176	$33	$0
PHYSICAL THERAPY	Hours	78	$121,218	9	47	$33	$14,652	0	47	$33	$419	1	47	$33	$1,395	1	47	$33	$1,321	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	175	$99,694	14	28	$25	$9,017	0	80	$25	$649	1	37	$25	$1,252	1	35	$25	$1,032	0	41	$25	$0
CRISES INTERVENTION	Client	20	$3,111	1	1	$156	$126	0	1	$156	$51	0	1	$156	$41	0	1	$156	$16	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	34	$496,300	7	263	$35	$62,100	1	394	$35	$13,800	0	197	$35	$2,367	1	263	$35	$6,900	0	329	$35	$0
PSYCHO- THERAPY	Hours	8	$1,833	1	40	$8	$173	0	72	$8	$58	0	36	$8	$12	0	48	$8	$19	0	60	$8	$0
PERSONAL CARE SVCS	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	236	$62,500	27	1	$150	$4,050	1	1	$200	$200	2	1	$125	$250	5	1	$100	$500	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	30	$57	$0	0	50	$57	$0
ACUTE CARE	Client	300	$150,000	27	1	$500	$13,500	1	1	$500	$500	2	1	$500	$1,000	5	1	$500	$2,500	0	1	$500	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	300	$287,881	27	11.40	$331	$12,467	1	######	$3,971	$66,608	2	6.41	$1,316	$19,421	5	13.47	$822	$14,271	0	10.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0

TABLE F.4
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, ALL AGES
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIV #	ALL TOTAL COST	6 OTHER SKL2 INDIV #	UNIT #	UNIT COST	TOTAL COST	7 BEH-OVRDG SKL3 INDIV #	UNIT #	UNIT COST	TOTAL COST	8 CHRONIC SKL3 INDIV #	UNIT #	UNIT COST	TOTAL COST	9 OTHER SKL3 INDIV #	UNIT #	UNIT COST	TOTAL COST	10 OTHER SKL4 INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	439	$34,436	28	1	$124	$3,472	2	1	$124	$248	2	1	$124	$248	6	1	$124	$744	0	0	$124	$0
INDIV PLNG & MONITORING	Hours	439	$629,965	28	41	$35	$40,180	2	41	$35	$2,870	2	41	$35	$2,870	6	41	$35	$8,610	0	0	$35	$0
CLUSTER MANAGEMENT	Client	439	$658,500	28	1	$1,500	$42,000	2	1	$1,500	$3,000	2	1	$1,500	$3,000	6	1	$1,500	$9,000	0	0	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	97	$7,131,810	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$33	$0	0	0	$46	$0
ICF-MR IVB BEHVR MGMT	Days	10	$810,300	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$33	$0	0	0	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$33	$0	0	0	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$93	$0	0	0	$146	$0	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME IVB BEHVR MGMT	Days	3	$294,920	0	0	$93	$0	2	365	$146	$106,580	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME III HIGH SUPV	Days	208	$8,030,847	0	0	$93	$0	0	0	$146	$0	0	0	$57	$0	6	365	$28	$61,320	0	0	$24	$0
GRP HOME II MOD SUPV	Days	31	$1,894,204	20	365	$93	$679,630	0	0	$146	$0	0	0	$57	$0	1	365	$20	$5,110	0	0	$24	$0
GRP HOME I MIN SUPV	Days	4	$50,316	0	0	$93	$0	0	0	$146	$0	1	365	$37	$24,966	3	365	$20	$23,330	0	0	$24	$0
SPEC CARE IV FAMILY	Days	42	$464,200	0	0	$25	$0	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$13	$0
MED CARE III FAMILY	Days	1	$14,434	0	0	$25	$0	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$13	$0
SPEC CARE III/FAMILY	Days	14	$133,334	8	365	$25	$75,730	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$13	$0
SPEC CARE II FAMILY	Days	3	$19,710	0	0	$25	$0	0	0	$30	$0	1	365	$23	$7,300	2	365	$20	$12,410	0	0	$13	$0
SPEC CARE I FAMILY	Days	1	$8,760	0	0	$25	$0	0	0	$30	$0	0	0	$23	$0	1	365	$20	$8,760	0	0	$13	$0
INDEPENDENT W/RELATIVES	Days	10	$36,617	0	365	$10	$370	0	0	$10	$0	0	0	$10	$0	0	365	$19	$370	0	0	$10	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	4	$26,040	0	0	$31	$0	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$19	$0
INTEGRATED INF ST/PRE-SC	Days	1	$3,720	0	0	$31	$0	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$19	$0
WORK ACTIVITY	Days	158	$1,498,272	5	240	$32	$41,472	0	0	$40	$0	0	0	$29	$0	0	0	$25	$0	0	0	$22	$0
SHELTERED WORK	Days	30	$243,888	14	240	$32	$103,680	1	240	$40	$7,680	1	240	$29	$5,568	1	240	$25	$6,000	0	0	$22	$0
INTEGRATED ADULT SVCS	Days	12	$86,196	8	240	$32	$62,200	0	240	$40	$1,920	1	240	$29	$3,560	3	240	$25	$16,300	0	0	$22	$0
SUPPORTED EMPLOYMENT	Days	2	$8,613	0	0	$24	$0	0	0	$30	$0	0	240	$22	$2,080	1	240	$19	$6,325	0	0	$17	$0
HOME-BASED TRAINING	Hours	19	$181,920	0	600	$16	$2,000	0	0	$16	$0	0	0	$16	$0	0	500	$16	$2,400	0	0	$16	$0
SPCH & HRNG THERAPY	Hours	90	$243,917	9	113	$33	$33,705	0	164	$33	$2,200	0	141	$33	$2,276	2	152	$33	$8,276	0	0	$33	$0
PHYSICAL THERAPY	Hours	80	$123,699	9	47	$33	$14,652	0	47	$33	$419	1	47	$33	$1,393	1	47	$33	$1,321	0	0	$33	$0
OCCUPATIONAL THERAPY	Hours	125	$99,694	14	20	$25	$9,017	0	80	$25	$649	1	37	$25	$1,252	1	33	$25	$1,032	0	0	$25	$0
CRISES INTERVENTION	Client	28	$4,384	1	1	$136	$131	1	1	$136	$103	0	1	$156	$61	0	1	$136	$19	0	0	$136	$0
BEHAVIORAL CONSULTATION	Hours	76	$702,993	7	263	$35	$64,400	2	394	$35	$27,600	0	197	$35	$2,567	1	263	$35	$8,200	0	0	$35	$0
PSYCHO- THERAPY	Hours	12	$2,639	1	40	$0	$179	0	72	$0	$115	0	36	$0	$12	0	48	$0	$23	0	0	$0	$0
PERSONAL CARE SVCS	Visit	10	$105,393	0	75	$57	$428	0	0	$57	$0	0	0	$57	$0	0	30	$57	$205	0	0	$57	$0
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	332	$87,850	28	1	$150	$4,200	2	1	$200	$400	2	1	$125	$250	6	1	$100	$600	0	0	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	439	$300,000	28	1	$2,750	$15,300	2	1	$2,750	$2,500	2	1	$500	$1,000	6	1	$2,750	$4,500	0	0	$500	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	439	$334,967	28	1	$201	$12,630	2	9	$3,694	$67,035	2	6	$1,316	$19,421	6	3	$734	$15,874	0	0	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	9	$13,050	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0
LEVEL III RESPITE	Days	1	$1,176	0	28	$40	$56	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0
LEVEL II RESPITE	Days	0	$63	0	21	$30	$32	0	0	$30	$0	0	0	$30	$0	0	21	$30	$32	0	0	$30	$0
LEVEL I RESPITE	Days	0	$26	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	21	$25	$26	0	0	$25	$0

TABLE F.4 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
GEORGIA RETARDATION CENTER, ALL AGES
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	ALL(1-10) INDIV #	ALL(1-10) TOTAL COST	1 MED/PHYS OVRDG SKL1 INDIV #	UNIT #	UNIT COST	TOTAL COST	2 BEH-OVRDG SKL1 INDIV #	UNIT #	UNIT COST	TOTAL COST	3 CHRONIC&OTHER SKL1 INDIV #	UNIT #	UNIT COST	TOTAL COST	4 BEH-OVRDG SKL2 INDIV #	UNIT #	UNIT COST	TOTAL COST	5 CHRONIC SKL2 INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	439	$54,436	97	1	$124	$12,028	10	1	$124	$1,240	253	1	$124	$31,372	3	1	$124	$372	38	1	$124	$4,712
INDIV PLNG & MONITORING	Hours	439	$629,963	97	41	$35	$139,195	10	41	$35	$14,350	253	41	$35	$363,055	3	41	$35	$4,305	38	41	$35	$54,530
CLUSTER MANAGEMENT	Client	439	$658,500	97	1	$1,500	$145,500	10	1	$1,500	$15,000	253	1	$1,500	$379,500	3	1	$1,500	$4,500	38	1	$1,500	$57,000
ICF-MR IVA MEDCL SUPV	Days	97	$7,151,810	97	365	$202	$7,151,810	0	0	$222	$0	0	0	$139	$0	0	0	$219	$0	0	0	$145	$0
ICF-MR IVB BEHVR MGMT	Days	10	$810,300	0	0	$202	$0	10	365	$222	$810,300	0	0	$159	$0	0	0	$219	$0	0	0	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$202	$0	0	0	$222	$0	0	0	$139	$0	0	0	$219	$0	0	0	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
GRP HOME IVB BEHVR MGMT	Days	3	$294,920	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	3	365	$172	$188,340	0	0	$109	$0
GRP HOME III HIGH SUPV	Days	200	$6,030,047	0	0	$139	$0	0	0	$172	$0	202	365	$119	$8,769,327	0	0	$172	$0	0	0	$109	$0
GRP HOME II MOD SUPV	Days	31	$1,094,204	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	30	365	$109	$1,209,464
GRP HOME I MIN SUPV	Days	4	$30,316	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
SPEC CARE IV FAMILY	Days	42	$464,200	0	0	$35	$0	0	0	$40	$0	42	365	$30	$464,200	0	0	$35	$0	0	0	$30	$0
MED CARE III FAMILY	Days	1	$14,454	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	1	365	$30	$14,454
SPEC CARE IIIFAMILY	Days	14	$133,334	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	3	365	$30	$37,816
SPEC CARE II FAMILY	Days	3	$19,710	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	0	0	$30	$0
SPEC CARE I FAMILY	Days	1	$8,760	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	0	0	$30	$0
INDEPENDENT W/RELATIVES	Days	10	$36,617	0	0	$10	$0	0	0	$10	$0	9	365	$10	$32,170	0	0	$10	$0	1	365	$10	$3,699
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SCI	Days	4	$26,040	0	0	$38	$0	0	0	$36	$0	4	240	$31	$26,040	0	0	$35	$0	0	0	$33	$0
INTEGRATED INF ST/PRE-SCI	Days	1	$3,720	0	0	$38	$0	0	0	$36	$0	1	240	$31	$3,720	0	0	$35	$0	0	0	$33	$0
WORK ACTIVITY	Days	150	$1,498,272	0	0	$43	$0	0	0	$50	$0	137	240	$40	$1,313,200	2	240	$47	$22,560	14	240	$36	$120,960
SHELTERED WORK	Days	30	$243,000	0	0	$43	$0	0	0	$50	$0	0	0	$40	$0	0	0	$47	$0	14	240	$36	$120,960
INTEGRATED ADULT SVCS	Days	12	$86,196	0	0	$43	$0	0	0	$30	$0	0	0	$40	$0	0	0	$47	$0	0	0	$36	$0
SUPPORTED EMPLOYMENT	Days	2	$8,613	0	0	$32	$0	0	0	$30	$0	0	0	$30	$0	0	0	$35	$0	0	0	$27	$0
HOME-BASED TRAINING	Hours	19	$101,920	0	0	$16	$0	0	0	$16	$0	16	600	$16	$157,440	0	0	$16	$0	2	600	$16	$19,200
SPCH & HRNG THERAPY	Hours	90	$243,917	0	0	$30	$0	0	0	$33	$0	60	70	$33	$157,303	1	129	$33	$2,980	10	113	$33	$37,130
PHYSICAL THERAPY	Hours	80	$123,699	0	0	$30	$0	0	0	$33	$0	56	47	$33	$87,325	0	47	$33	$352	12	47	$33	$18,234
OCCUPATIONAL THERAPY	Hours	125	$99,694	0	0	$30	$0	0	0	$25	$0	89	32	$25	$71,060	1	43	$25	$1,339	10	32	$25	$14,344
CRISES INTERVENTION	Client	28	$4,384	0	0	$136	$0	2	1	$136	$250	20	1	$136	$3,095	1	1	$156	$94	4	1	$156	$652
BEHAVIORAL CONSULTATION	Hours	76	$702,993	0	0	$35	$0	0	0	$35	$0	51	263	$35	$465,320	3	394	$35	$41,400	12	219	$35	$93,227
PSYCHO- THERAPY	Hours	12	$2,639	0	0	$8	$0	0	0	$8	$0	10	24	$8	$1,943	0	72	$8	$173	1	32	$8	$195
PERSONAL CARE SVCS	Visit	10	$105,393	0	0	$37	$0	0	0	$37	$0	9	200	$37	$99,100	0	0	$37	$0	1	100	$37	$3,700
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	332	$89,850	0	0	$600	$0	0	0	$400	$0	253	1	$300	$75,900	3	1	$300	$900	38	1	$200	$7,600
HOME HEALTH SERVICES	Visit	0	$0	0	0	$37	$0	0	0	$37	$0	0	0	$37	$0	0	0	$37	$0	0	0	$37	$0
ACUTE CARE	Client	439	$500,000	97	1	$2,750	$152,000	10	1	$2,750	$8,000	253	1	$2,750	$279,300	3	1	$2,750	$3,000	38	1	$2,750	$34,000
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	439	$334,967	97	2	$355	$51,660	10	2	$385	$6,250	253	1	$275	$89,683	3	0	$2,255	$55,070	38	1	$306	$17,316
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	9	$13,050	0	0	$50	$0	0	0	$50	$0	9	30	$50	$13,050	0	0	$50	$0	0	0	$50	$0
LEVEL III RESPITE	Days	1	$1,176	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	1	28	$40	$1,120
LEVEL II RESPITE	Days	0	$63	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0
LEVEL I RESPITE	Days	0	$26	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0

TABLE F.5
PROJECTED SERVICE REQUIREMENTS AND COSTS
SOUTHWESTERN DEVELOPMENTAL CENTER @ BAINBRIDGE
AGES 6-21
WAIVER STRATEGY

YEAR 0

		ALL(1-10)		1 MED/PHYS OVRDG SKLIV				2 BEH-OVRDG SKLIV				3 CHRONIC&OTHER SKLIV				4 BEH-OVRDG SKLIII				5 CHRONIC SKLIII			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	43	$5,332	1	1	$124	$124	3	1	$124	$372	28	1	$124	$3,472	0	1	$124	$0	4	1	$124	$496
INDIV PLNG & MONITORING	Hours	43	$61,705	1	41	$35	$1,435	3	41	$35	$4,305	28	41	$35	$40,180	0	41	$35	$0	4	41	$35	$5,740
CLUSTER MANAGEMENT	Client	43	$64,500	1	1	$1,500	$1,500	3	1	$1,500	$4,500	28	1	$1,500	$42,000	0	1	$1,500	$0	4	1	$1,500	$6,000
ICF-MR IVA MEDCL SUPV	Days	1	$73,730	1	365	$202	$73,730	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	3	$243,090	0	365	$202	$0	3	365	$222	$243,090	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	22	$972,944	0	365	$139	$0	0	365	$172	$0	22	365	$119	$972,944	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	0	$273,641	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	3	365	$109	$127,312
GRP HOME I MIN SUPV	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	3	$30,660	0	365	$35	$0	0	365	$40	$0	3	365	$30	$30,660	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$876	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$876
SPEC CARE IIIFAMILY	Days	1	$12,629	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$3,504
SPEC CARE II FAMILY	Days	1	$5,475	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	4	$14,425	0	365	$10	$0	0	365	$10	$0	3	365	$10	$10,336	0	365	$10	$0	0	365	$10	$1,479
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	24	$181,920	0	240	$38	$0	0	240	$36	$0	20	240	$31	$145,824	0	240	$35	$0	2	240	$33	$19,000
INTEGRATED INF ST/PRE-SC	Days	6	$43,848	0	240	$38	$0	0	240	$36	$0	3	240	$31	$20,032	0	240	$35	$0	1	240	$33	$6,336
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	0	$1,044	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	9	$81,600	0	600	$16	$0	0	600	$16	$0	6	600	$16	$53,760	0	700	$16	$0	1	600	$16	$7,680
SPCH & HRNG THERAPY	Hours	14	$33,131	0	36	$30	$0	0	72	$33	$0	11	60	$33	$21,344	0	110	$33	$0	1	96	$33	$4,324
PHYSICAL THERAPY	Hours	13	$21,051	0	40	$30	$0	0	48	$33	$0	9	48	$33	$14,193	0	48	$33	$0	2	48	$33	$2,661
OCCUPATIONAL THERAPY	Hours	0	$0	0	12	$30	$0	0	12	$25	$0	0	24	$25	$0	0	32	$25	$0	0	24	$25	$0
CRISES INTERVENTION	Client	4	$557	0	1	$156	$0	0	1	$156	$75	2	1	$156	$349	0	1	$156	$0	0	1	$156	$69
BEHAVIORAL CONSULTATION	Hours	9	$45,701	0	80	$35	$0	0	239	$35	$0	6	160	$35	$31,282	0	239	$35	$0	1	133	$35	$5,958
PSYCHO- THERAPY	Hours	1	$279	0	24	$8	$0	0	72	$8	$0	1	24	$8	$215	0	72	$8	$0	0	32	$8	$20
PERSONAL CARE SVCS	Visit	4	$37,193	0	250	$57	$0	0	250	$57	$0	3	200	$57	$31,920	0	150	$57	$0	0	100	$57	$2,280
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	39	$10,200	0	1	$600	$0	0	1	$400	$0	28	1	$300	$8,400	0	1	$300	$0	4	1	$200	$800
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$6	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	43	$86,000	1	1	$2,000	$2,000	3	1	$2,000	$6,000	28	1	$2,000	$56,000	0	1	$2,000	$0	4	1	$2,000	$8,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	43	$10,894	1	1.50	$355	$533	3	1.63	$305	$1,075	28	1.00	$237	$6,620	0	0.00	$0	$0	4	0.92	$218	$801
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	3	$4,200	0	30	$50	$0	0	30	$50	$0	3	30	$50	$4,200	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	1	$720	0	20	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$448
LEVEL II RESPITE	Days	0	$280	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.5 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
SOUTHWESTERN DEVELOPMENTAL CENTER @ BAINBRIDGE
AGES 6-21
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIV #	ALL TOTAL COST	6 OTHER SKL INDIV #	6 OTHER SKL UNITS #	6 OTHER SKL UNIT COST	6 OTHER SKL TOTAL COST	7 BEH-OVRDG SKL INDIV #	7 BEH-OVRDG SKL UNITS #	7 BEH-OVRDG SKL UNIT COST	7 BEH-OVRDG SKL TOTAL COST	8 CHRONIC SKL INDIV #	8 CHRONIC SKL UNITS #	8 CHRONIC SKL UNIT COST	8 CHRONIC SKL TOTAL COST	9 OTHER SKL INDIV #	9 OTHER SKL UNITS #	9 OTHER SKL UNIT COST	9 OTHER SKL TOTAL COST	10 OTHER SKL INDIV #	10 OTHER SKL UNITS #	10 OTHER SKL UNIT COST	10 OTHER SKL TOTAL COST
DIAGNOSIS & EVALUATION	Client	43	$5,332	5	1	$124	$620	0	1	$124	$0	2	1	$124	$248	0	1	$124	$0	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	43	$61,705	5	41	$35	$7,175	0	41	$35	$0	2	41	$35	$2,870	0	41	$35	$0	0	41	$35	$0
CLUSTER MANAGEMENT	Client	43	$64,500	5	1	$1,500	$7,500	0	1	$1,500	$0	2	1	$1,500	$3,000	0	1	$1,500	$0	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	1	$73,730	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	3	$243,090	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	22	$972,944	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
GRP HOME II MOD SUPV	Days	8	$273,641	4	365	$95	$121,363	0	365	$146	$0	1	365	$57	$24,966	0	365	$20	$0	0	365	$24	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$20	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	3	$30,660	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	0	$876	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	1	$12,629	1	365	$25	$9,125	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	1	$5,475	0	365	$25	$0	0	365	$30	$0	1	365	$25	$5,475	0	365	$20	$0	0	365	$15	$0
SPEC CARE I FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	4	$14,425	1	365	$10	$1,849	0	365	$10	$0	0	365	$10	$740	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	24	$181,920	2	240	$31	$14,880	0	240	$30	$0	0	240	$23	$2,208	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	6	$43,040	2	240	$31	$11,160	0	240	$30	$0	1	240	$23	$5,320	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	0	$1,044	0	240	$24	$0	0	240	$30	$0	0	240	$22	$1,044	0	240	$19	$0	0	240	$17	$0
HOME-BASED TRAINING	Hours	9	$81,600	2	600	$16	$14,400	0	700	$16	$0	1	600	$16	$5,760	0	500	$16	$0	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	14	$33,131	2	96	$33	$5,322	0	140	$33	$0	0	120	$33	$1,940	0	130	$33	$0	0	150	$33	$0
PHYSICAL THERAPY	Hours	13	$21,031	2	48	$33	$2,772	0	48	$33	$0	1	48	$33	$1,426	0	48	$33	$0	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	21	$25	$0	0	60	$25	$0	0	28	$25	$0	0	26	$25	$0	0	31	$25	$0
CRISES INTERVENTION	Client	4	$557	0	1	$156	$23	0	1	$156	$0	0	1	$156	$41	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	9	$45,781	1	160	$35	$6,983	0	239	$35	$0	0	120	$35	$1,550	0	160	$35	$0	0	200	$35	$0
PSYCHO- THERAPY	Hours	1	$279	0	40	$8	$32	0	72	$8	$0	0	36	$8	$12	0	48	$8	$0	0	60	$8	$0
PERSONAL CARE SVCS	Visit	4	$37,193	1	75	$57	$2,138	0	150	$57	$0	0	75	$57	$855	0	50	$57	$0	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	39	$10,200	5	1	$150	$750	0	1	$200	$0	2	1	$125	$250	0	1	$100	$0	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	30	$57	$0
ACUTE CARE	Client	43	$86,000	5	1	$2,000	$10,000	0	1	$2,000	$0	2	1	$2,000	$4,000	0	1	$2,000	$0	0	1	$2,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	43	$10,094	5	0.83	$196	$815	0	0.00	$0	$0	2	0.72	$169	$242	0	0.00	$0	$0	0	0.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	3	$4,200	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	1	$720	0	28	$40	$200	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$204	0	21	$30	$150	0	21	$30	$0	0	21	$30	$126	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0

TABLE F.6
PROJECTED SERVICE REQUIREMENTS AND COSTS
SOUTHWESTERN DEVELOPMENTAL CENTER' @ BAINBRIDGE
AGES 22+
WAIVER STRATEGY

YEAR 0

		ALL(1-10)		1 MED/PHYS OVRDG SKLIV				2 BEH-OVRDG SKLIV				3 CHRONIC&OTHER SKLIV				4 BEH-OVRDG SKLIII				5 CHRONIC SKLIII			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	153	$10,972	3	1	$124	$372	14	1	$124	$1,736	105	1	$124	$13,020	1	1	$124	$124	17	1	$124	$2,108
INDIV PLNS & MONITORING	Hours	153	$219,555	3	41	$35	$4,305	14	41	$35	$20,090	105	41	$35	$150,675	1	41	$35	$1,435	17	41	$35	$24,395
CLUSTER MANAGEMENT	Client	153	$229,500	3	1	$1,500	$4,500	14	1	$1,500	$21,000	105	1	$1,500	$157,500	1	1	$1,500	$1,500	17	1	$1,500	$25,500
ICF-MR IVA MEDCL SUPV	Days	3	$221,190	3	365	$202	$221,190	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	14	$1,134,420	0	365	$202	$0	14	365	$222	$1,134,420	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	2	$116,070	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	1	365	$172	$62,780	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	88	$3,689,420	0	365	$159	$0	0	365	$172	$0	84	365	$119	$3,648,540	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	10	$606,711	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	14	365	$109	$341,076
GRP HOME I MIN SUPV	Days	3	$45,406	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	21	$229,950	0	365	$35	$0	0	365	$40	$0	21	365	$30	$229,950	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	1	$7,446	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$7,446
SPEC CARE IIIFAMILY	Days	5	$46,209	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	3	365	$30	$29,784
SPEC CARE II FAMILY	Days	2	$16,060	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	1	$5,840	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	95	$900,336	0	240	$43	$0	0	240	$50	$0	84	240	$40	$806,400	1	240	$47	$11,280	9	240	$36	$73,440
SHELTERED WORK	Days	14	$114,528	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	9	240	$36	$73,440
INTEGRATED ADULT SVCS	Days	5	$34,512	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	1	$6,588	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	600	$16	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0
SPCH & HRNG THERAPY	Hours	31	$116,307	0	36	$30	$0	0	72	$33	$0	40	60	$33	$80,042	0	110	$33	$1,271	6	96	$33	$19,227
PHYSICAL THERAPY	Hours	45	$70,971	0	48	$30	$0	0	48	$33	$0	34	48	$33	$53,222	0	48	$33	$100	7	48	$33	$11,310
OCCUPATIONAL THERAPY	Hours	72	$43,444	0	12	$30	$0	0	12	$25	$0	34	24	$25	$32,659	1	32	$25	$501	11	24	$25	$6,610
CRISES INTERVENTION	Client	14	$2,115	0	1	$156	$0	2	1	$156	$349	0	1	$156	$1,310	0	1	$156	$31	2	1	$156	$292
BEHAVIORAL CONSULTATION	Hours	31	$172,676	0	80	$35	$0	0	239	$35	$0	21	160	$35	$117,306	1	239	$35	$8,379	5	133	$35	$25,323
PSYCHO- THERAPY	Hours	5	$1,074	0	24	$8	$0	0	72	$8	$0	4	24	$8	$806	0	72	$8	$58	0	32	$8	$87
PERSONAL CARE SVCS	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	290	$57	$0	0	150	$57	$0	0	100	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	136	$36,950	0	1	$600	$0	0	1	$400	$0	105	1	$300	$31,500	1	1	$300	$300	17	1	$200	$3,400
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	153	$76,500	3	1	$500	$1,500	14	1	$500	$7,000	105	1	$500	$52,500	1	1	$500	$500	17	1	$500	$8,500
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	153	$65,635	3	1.50	$355	$1,598	14	1.63	$385	$8,751	105	1.32	$312	$43,305	1	2.60	$615	$1,600	17	1.06	$252	$4,556
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.6 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
SOUTHWESTERN DEVELOPMENTAL CENTER @ BAINBRIDGE
AGES 22+
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIV #	ALL TOTAL COST	6 OTHER SKL INDIV #	6 OTHER SKL UNIT #	6 OTHER SKL UNIT COST	6 OTHER SKL TOTAL COST	7 BEH-OVRDG SKL INDIV #	7 BEH-OVRDG SKL UNIT #	7 BEH-OVRDG SKL UNIT COST	7 BEH-OVRDG SKL TOTAL COST	8 CHRONIC SKL INDIV #	8 CHRONIC SKL UNIT #	8 CHRONIC SKL UNIT COST	8 CHRONIC SKL TOTAL COST	9 OTHER SKL INDIV #	9 OTHER SKL UNIT #	9 OTHER SKL UNIT COST	9 OTHER SKL TOTAL COST	10 OTHER SKL INDIV #	10 OTHER SKL UNIT #	10 OTHER SKL UNIT COST	10 OTHER SKL TOTAL COST
DIAGNOSIS & EVALUATION	Client	153	$18,972	6	1	$124	$744	1	1	$124	$124	2	1	$124	$248	4	1	$124	$496	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	153	$219,555	6	41	$35	$8,610	1	41	$35	$1,435	2	41	$35	$2,870	4	41	$35	$5,740	0	41	$35	$0
CLUSTER MANAGEMENT	Client	153	$229,500	6	1	$1,500	$9,000	1	1	$1,500	$1,500	2	1	$1,500	$3,000	4	1	$1,500	$6,000	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	3	$221,190	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	14	$1,134,420	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	2	$116,070	0	365	$95	$0	1	365	$146	$53,290	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	80	$3,689,420	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	4	365	$28	$40,000	0	365	$24	$0
GRP HOME II MOD SUPV	Days	10	$686,711	4	365	$95	$145,635	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME I MIN SUPV	Days	3	$45,406	0	365	$95	$0	0	365	$146	$0	1	365	$57	$24,966	2	365	$28	$20,440	0	365	$24	$0
SPEC CARE IV FAMILY	Days	21	$229,950	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	1	$7,446	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	5	$46,209	2	365	$25	$16,425	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	2	$16,060	0	365	$25	$0	0	365	$30	$0	1	365	$25	$7,300	1	365	$20	$8,760	0	365	$15	$0
SPEC CARE I FAMILY	Days	1	$5,840	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	1	365	$20	$5,840	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SCL	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SCL	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	95	$900,336	1	240	$32	$9,216	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	14	$114,528	3	240	$32	$23,040	1	240	$40	$7,680	1	240	$29	$5,368	1	240	$25	$4,800	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	5	$34,512	2	240	$32	$13,824	0	240	$40	$1,920	1	240	$29	$5,568	2	240	$25	$13,200	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	1	$6,508	0	240	$24	$0	0	240	$30	$0	0	240	$22	$2,008	1	240	$19	$4,500	0	240	$17	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0	0	500	$16	$0	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	51	$116,307	2	96	$33	$6,307	0	140	$33	$1,876	0	120	$33	$1,940	1	130	$33	$5,646	0	150	$33	$0
PHYSICAL THERAPY	Hours	45	$70,971	2	48	$33	$3,326	0	48	$33	$420	1	48	$33	$1,426	1	48	$33	$1,080	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	72	$43,444	3	21	$25	$1,633	0	60	$25	$486	1	20	$25	$937	1	26	$25	$618	0	31	$25	$0
CRISES INTERVENTION	Client	14	$2,115	0	1	$156	$28	0	1	$156	$51	0	1	$156	$41	0	1	$156	$12	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	31	$172,676	2	160	$35	$8,379	1	239	$35	$8,379	0	120	$35	$1,350	1	160	$35	$3,352	0	200	$35	$0
PSYCHO- THERAPY	Hours	5	$1,074	0	40	$8	$38	0	72	$8	$58	0	36	$8	$12	0	48	$8	$15	0	60	$8	$0
PERSONAL CARE SVCS	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	136	$34,950	6	1	$150	$900	1	1	$200	$200	2	1	$125	$250	4	1	$100	$400	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
ACUTE CARE	Client	153	$76,500	6	1	$500	$3,000	1	1	$500	$500	2	1	$500	$1,000	4	1	$500	$2,000	0	1	$500	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	153	$65,635	6	11.04	$247	$1,343	1	12.20	$521	$1,146	2	11.11	$262	$578	4	11.64	$389	$2,558	0	10.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0

TABLE F.7
PROJECTED SERVICE REQUIREMENTS AND COSTS
SOUTHWESTERN DEVELOPMENTAL CENTER @ BAINBRIDGE
ALL AGES
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	ALL(1-10)		1 MED/PHYS OVRBG SKL1				2 BEH-OVRBG SKL1				3 CHRONIC&OTHER SKL1				4 BEH-OVRBG SKL2				5 CHRONIC SKL2			
		INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	196	$24,304	4	1	$124	$496	17	1	$124	$2,108	133	1	$124	$16,492	1	1	$124	$124	21	1	$124	$2,604
INDIV PLNG & MONITORING	Hours	196	$281,260	4	41	$35	$5,740	17	41	$35	$24,395	133	41	$35	$190,855	1	41	$35	$1,435	21	41	$35	$30,135
CLUSTER MANAGEMENT	Client	196	$294,000	4	1	$1,500	$6,000	17	1	$1,500	$25,500	133	1	$1,500	$199,500	1	1	$1,500	$1,500	21	1	$1,500	$31,500
ICF-MR IVA MEDCL SUPV	Days	4	$294,920	4	365	$202	$294,920	0	0	$222	$0	0	0	$139	$0	0	0	$219	$0	0	0	$145	$0
ICF-MR IVB BEHVR MGMT	Days	17	$1,377,310	0	0	$202	$0	17	365	$222	$1,377,310	0	0	$139	$0	0	0	$219	$0	0	0	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$202	$0	0	0	$222	$0	0	0	$139	$0	0	0	$219	$0	0	0	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
GRP HOME IVB BEHVR MGMT	Days	2	$116,070	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	1	365	$172	$62,780	0	0	$109	$0
GRP HOME III HIGH SUPV	Days	110	$4,642,364	0	0	$139	$0	0	0	$172	$0	106	365	$119	$4,621,484	0	0	$172	$0	0	0	$109	$0
GRP HOME II MOD SUPV	Days	26	$960,352	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	17	365	$109	$660,380
GRP HOME I MIN SUPV	Days	3	$43,406	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
SPEC CARE IV FAMILY	Days	24	$260,610	0	0	$35	$0	0	0	$40	$0	24	365	$30	$260,610	0	0	$35	$0	0	0	$30	$0
MED CARE III FAMILY	Days	1	$8,322	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	1	365	$30	$8,322
SPEC CARE IIIFAMILY	Days	6	$38,838	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	3	365	$30	$33,288
SPEC CARE II FAMILY	Days	3	$21,535	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	0	0	$30	$0
SPEC CARE I FAMILY	Days	1	$5,040	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	0	0	$30	$0
INDEPENDENT W/RELATIVES	Days	4	$14,425	0	0	$10	$0	0	0	$10	$0	3	365	$10	$10,356	0	0	$10	$0	0	365	$10	$1,479
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	24	$181,920	0	0	$38	$0	0	0	$36	$0	20	240	$31	$145,824	0	0	$35	$0	2	240	$33	$19,008
INTEGRATED INF ST/PRE-SC	Days	6	$43,848	0	0	$38	$0	0	0	$36	$0	3	240	$31	$20,832	0	0	$35	$0	1	240	$33	$6,336
WORK ACTIVITY	Days	93	$900,336	0	0	$43	$0	0	0	$50	$0	84	240	$40	$806,400	1	240	$47	$11,280	9	240	$36	$73,440
SHELTERED WORK	Days	14	$114,528	0	0	$43	$0	0	0	$50	$0	0	0	$40	$0	0	0	$47	$0	9	240	$36	$73,440
INTEGRATED ADULT SVCS	Days	3	$34,512	0	0	$43	$0	0	0	$50	$0	0	0	$40	$0	0	0	$47	$0	0	0	$36	$0
SUPPORTED EMPLOYMENT	Days	2	$7,632	0	0	$32	$0	0	0	$38	$0	0	0	$30	$0	0	0	$35	$0	0	0	$27	$0
HOME-BASED TRAINING	Hours	9	$81,600	0	0	$16	$0	0	0	$16	$0	6	600	$16	$33,760	0	0	$16	$0	1	600	$16	$7,600
SPCH & HRNG THERAPY	Hours	65	$149,510	0	0	$30	$0	0	0	$33	$0	51	60	$33	$101,386	0	110	$33	$1,271	7	96	$33	$23,750
PHYSICAL THERAPY	Hours	58	$92,025	0	0	$30	$0	0	0	$33	$0	43	48	$33	$67,415	0	48	$33	$180	9	48	$33	$13,971
OCCUPATIONAL THERAPY	Hours	72	$43,444	0	0	$30	$0	0	0	$25	$0	34	24	$25	$32,639	1	32	$25	$501	11	24	$25	$6,610
CRISES INTERVENTION	Client	17	$2,672	0	0	$156	$0	3	1	$156	$424	11	1	$156	$1,660	0	1	$156	$31	2	1	$156	$360
BEHAVIORAL CONSULTATION	Hours	39	$218,437	0	0	$35	$0	0	0	$35	$0	27	160	$35	$148,588	1	239	$35	$8,379	7	133	$35	$31,282
PSYCHO- THERAPY	Hours	6	$1,353	0	0	$8	$0	0	0	$8	$0	3	24	$8	$1,071	0	72	$8	$58	0	32	$8	$100
PERSONAL CARE SVCS	Visit	4	$37,193	0	0	$57	$0	0	0	$57	$0	3	200	$57	$31,920	0	0	$57	$0	0	100	$57	$2,280
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,800	$0	0	0	$1,800	$0	0	0	$1,800	$0	0	0	$1,800	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	175	$47,150	0	0	$600	$0	0	0	$400	$0	133	1	$300	$39,900	1	1	$300	$300	21	1	$200	$4,200
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	196	$162,500	4	1	$1,250	$3,500	17	1	$1,250	$13,000	133	1	$1,250	$108,500	1	1	$1,250	$500	21	1	$1,250	$16,500
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	196	$76,529	4	2	$355	$2,130	17	2	$385	$10,626	133	1	$280	$49,932	1	3	$615	$1,600	21	1	$236	$5,350
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	3	$4,200	0	0	$50	$0	0	0	$50	$0	3	30	$50	$4,200	0	0	$50	$0	0	0	$50	$0
LEVEL III RESPITE	Days	1	$728	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	28	$40	$448
LEVEL II RESPITE	Days	0	$280	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0
LEVEL I RESPITE	Days	0	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0

TABLE F.7 p2

PROJECTED SERVICE REQUIREMENTS AND COSTS
SOUTHWESTERN DEVELOPMENTAL CENTER @ BAINBRIDGE
ALL AGES
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIV #	ALL TOTAL COST	6 OTHER SKL2 INDIV #	6 OTHER SKL2 UNIT #	6 OTHER SKL2 UNIT COST	6 OTHER SKL2 TOTAL COST	7 BEH-OVRBG SKL3 INDIV #	7 BEH-OVRBG SKL3 UNIT #	7 BEH-OVRBG SKL3 UNIT COST	7 BEH-OVRBG SKL3 TOTAL COST	8 CHRONIC SKL3 INDIV #	8 CHRONIC SKL3 UNIT #	8 CHRONIC SKL3 UNIT COST	8 CHRONIC SKL3 TOTAL COST	9 OTHER SKL3 INDIV #	9 OTHER SKL3 UNIT #	9 OTHER SKL3 UNIT COST	9 OTHER SKL3 TOTAL COST	10 OTHER SKL4 INDIV #	10 OTHER SKL4 UNIT #	10 OTHER SKL4 UNIT COST	10 OTHER SKL4 TOTAL COST
DIAGNOSIS & EVALUATION	Client	196	$24,304	11	1	$124	$1,364	1	1	$124	$124	4	1	$124	$496	4	1	$124	$496	0	0	$124	$0
INDIV PLNG & MONITORING	Hours	196	$281,260	11	41	$35	$15,785	1	41	$35	$1,435	4	41	$35	$5,740	4	41	$35	$5,740	0	0	$35	$0
CLUSTER MANAGEMENT	Client	196	$294,000	11	1	$1,500	$16,500	1	1	$1,500	$1,500	4	1	$1,500	$6,000	4	1	$1,500	$6,000	0	0	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	4	$294,920	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
ICF-MR IVB BEHVR MGMT	Days	17	$1,377,310	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$95	$0	0	0	$146	$0	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME IVB BEHVR MGMT	Days	2	$116,070	0	0	$95	$0	1	365	$146	$53,290	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME III HIGH SUPV	Days	110	$4,662,364	0	0	$95	$0	0	0	$146	$0	0	0	$57	$0	4	365	$28	$40,880	0	0	$24	$0
GRP HOME II MOD SUPV	Days	26	$960,352	8	365	$95	$266,990	0	0	$146	$0	1	365	$57	$24,966	0	0	$28	$0	0	0	$24	$0
GRP HOME I MIN SUPV	Days	3	$43,406	0	0	$95	$0	0	0	$146	$0	1	365	$57	$24,966	2	365	$28	$20,440	0	0	$24	$0
SPEC CARE IV FAMILY	Days	24	$260,610	0	0	$25	$0	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$15	$0
MED CARE III FAMILY	Days	1	$8,322	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
SPEC CARE IIIFAMILY	Days	6	$50,030	3	365	$25	$25,550	0	0	$30	$0	0	0	$23	$0	0	0	$20	$0	0	0	$15	$0
SPEC CARE II FAMILY	Days	3	$21,335	0	0	$25	$0	0	0	$30	$0	1	365	$25	$12,775	1	365	$20	$8,760	0	0	$15	$0
SPEC CARE I FAMILY	Days	1	$5,040	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	1	365	$20	$5,840	0	0	$15	$0
INDEPENDENT W/RELATIVES	Days	4	$14,425	1	365	$10	$1,849	0	0	$10	$0	0	365	$10	$740	0	0	$10	$0	0	0	$10	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	24	$181,920	2	240	$31	$14,880	0	0	$30	$0	0	240	$23	$2,200	0	0	$20	$0	0	0	$19	$0
INTEGRATED INF ST/PRE-SC	Days	6	$43,040	2	240	$31	$11,160	0	0	$30	$0	1	240	$23	$5,520	0	0	$20	$0	0	0	$19	$0
WORK ACTIVITY	Days	95	$900,336	1	240	$32	$9,216	0	0	$40	$0	0	0	$29	$0	0	0	$25	$0	0	0	$22	$0
SHELTERED WORK	Days	14	$114,528	3	240	$32	$23,040	1	240	$40	$7,680	1	240	$29	$5,568	1	240	$25	$4,800	0	0	$22	$0
INTEGRATED ADULT SVCS	Days	5	$34,512	2	240	$32	$13,824	0	240	$40	$1,920	1	240	$29	$5,568	2	240	$25	$13,200	0	0	$22	$0
SUPPORTED EMPLOYMENT	Days	2	$7,632	0	0	$24	$0	0	0	$30	$0	1	240	$22	$3,132	1	240	$19	$4,560	0	0	$17	$0
HOME-BASED TRAINING	Hours	9	$81,600	2	600	$16	$14,400	0	0	$16	$0	1	600	$16	$5,760	0	0	$16	$0	0	0	$16	$0
SPCH & HRNG THERAPY	Hours	63	$149,310	4	96	$33	$11,709	0	160	$33	$1,076	1	120	$33	$3,881	1	130	$33	$5,646	0	0	$33	$0
PHYSICAL THERAPY	Hours	50	$92,023	4	48	$33	$6,098	0	40	$33	$428	2	40	$33	$2,851	1	40	$33	$1,066	0	0	$33	$0
OCCUPATIONAL THERAPY	Hours	72	$43,444	3	21	$25	$1,633	0	60	$25	$406	1	28	$25	$937	1	26	$25	$618	0	0	$25	$0
CRISES INTERVENTION	Client	17	$2,672	0	1	$156	$31	0	1	$156	$31	1	1	$156	$81	0	1	$156	$12	0	0	$156	$0
BEHAVIORAL CONSULTATION	Hours	39	$218,457	3	160	$35	$15,362	1	239	$35	$8,379	1	120	$35	$3,117	1	160	$35	$3,332	0	0	$35	$0
PSYCHO- THERAPY	Hours	6	$1,353	0	40	$8	$70	0	72	$8	$58	0	36	$8	$23	0	40	$8	$15	0	0	$8	$0
PERSONAL CARE SVCS	Visit	4	$37,193	1	75	$57	$2,138	0	0	$57	$0	0	75	$57	$855	0	0	$57	$0	0	0	$57	$0
TRANSPORT- ATION	Client	0	$0	0	0	$1,800	$0	0	0	$1,800	$0	0	0	$1,800	$0	0	0	$1,800	$0	0	0	$1,800	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	175	$47,150	11	1	$150	$1,650	1	1	$200	$200	4	1	$125	$500	4	1	$100	$400	0	0	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	196	$162,500	11	1	$1,250	$13,000	1	1	$1,250	$500	4	1	$1,250	$5,000	4	1	$1,250	$2,000	0	0	$1,250	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	196	$76,529	11	1	$224	$2,359	1	2	$521	$1,146	4	1	$225	$820	4	2	$389	$2,558	0	0	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	3	$4,200	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0
LEVEL III RESPITE	Days	1	$720	0	20	$40	$280	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0
LEVEL II RESPITE	Days	0	$204	0	21	$30	$150	0	0	$30	$0	0	21	$30	$126	0	0	$30	$0	0	0	$30	$0
LEVEL I RESPITE	Days	0	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0

TABLE F.8
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, AGES 0-5
WAIVER STRATEGY

YEAR 0

		ALL(1-10)		1 MED/PHYS OVRDG SKL IV				2 BEH-OVRDG SKL IV				3 CHRONIC&OTHER SKL IV				4 BEH-OVRDG SKL III				5 CHRONIC SKL III			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	49	$6,076	6	1	$124	$744	0	1	$124	$0	0	1	$124	$0	3	1	$124	$372	17	1	$124	$2,108
INDIV PLAN & MONITORING	Hours	49	$70,315	6	41	$35	$8,610	0	41	$35	$0	0	41	$35	$0	3	41	$35	$4,305	17	41	$35	$24,395
CLUSTER MANAGEMENT	Client	49	$73,500	6	1	$1,500	$9,000	0	1	$1,500	$0	0	1	$1,500	$0	3	1	$1,500	$4,500	17	1	$1,500	$25,500
ICF-MR IVA MEDCL SUPV	Days	6	$442,380	6	365	$202	$442,380	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGNT	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGNT	Days	2	$130,672	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	2	365	$172	$130,672	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	8	$81,760	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	23	$714,196	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	12	365	$109	$473,442
GRP HOME I MIN SUPV	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$3,723	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$3,723
SPEC CARE IIIFAMILY	Days	2	$24,017	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$14,092
SPEC CARE II FAMILY	Days	3	$39,055	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	2	$11,680	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	9	$31,009	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	1	365	$10	$2,219	3	365	$10	$12,375
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	17	$130,704	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	2	240	$35	$20,160	10	240	$33	$80,784
INTEGRATED INF ST/PRE-SC	Days	17	$98,928	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$2,320	3	240	$33	$26,928
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	0	$0	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	9	$85,600	0	600	$16	$0	0	600	$16	$0	0	600	$16	$0	0	700	$16	$3,360	3	600	$16	$32,640
SPCH & HRNG THERAPY	Hours	14	$37,800	0	42	$36	$0	0	84	$33	$0	0	70	$33	$0	1	129	$33	$4,470	6	113	$33	$22,540
PHYSICAL THERAPY	Hours	13	$23,403	0	70	$30	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$520	7	47	$33	$11,071
OCCUPATIONAL THERAPY	Hours	0	$0	0	16	$30	$0	0	16	$25	$0	0	32	$25	$0	0	43	$25	$0	0	32	$25	$0
CRISES INTERVENTION	Client	0	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	13	$110,401	0	131	$35	$0	0	394	$35	$0	0	263	$35	$0	3	394	$35	$41,400	5	219	$35	$41,707
PSYCHO- THERAPY	Hours	1	$300	0	24	$8	$0	0	72	$8	$0	0	24	$8	$0	0	72	$8	$173	0	32	$8	$87
PERSONAL CARE SVCS	Visit	9	$41,895	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	1	130	$57	$5,130	3	100	$57	$19,380
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	63	$7,100	0	1	$600	$0	0	1	$400	$0	0	1	$300	$0	3	1	$300	$900	17	1	$200	$3,400
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	130	$57	$0	0	100	$57	$0
ACUTE CARE	Client	49	$392,000	6	1	$8,000	$48,000	0	1	$8,000	$0	0	1	$8,000	$0	3	1	$8,000	$24,000	17	1	$8,000	$136,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	49	$12,120	6	1.50	$355	$3,195	0	0.00	$0	$0	0	0.00	$0	$0	3	11.30	$308	$1,200	17	10.82	$194	$2,689
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	4	$4,368	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	3	28	$40	$3,000
LEVEL II RESPITE	Days	3	$2,079	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	1	$420	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.8 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, AGES 0-5
WAIVER STRATEGY

		ALL		6 OTHER SKL				7 BEH-DVRDG SKL				8 CHRONIC SKL				9 OTHER SKL				10 OTHER SKL			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	49	$6,076	5	1	$124	$620	0	1	$124	$0	10	1	$124	$1,240	8	1	$124	$992	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	49	$70,315	5	41	$35	$7,175	0	41	$35	$0	10	41	$35	$14,350	8	41	$35	$11,480	0	41	$35	$0
CLUSTER MANAGEMENT	Client	49	$73,500	5	1	$1,500	$7,500	0	1	$1,500	$0	10	1	$1,500	$15,000	8	1	$1,500	$12,000	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	6	$442,380	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	2	$150,672	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	8	$81,760	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	8	365	$28	$81,760	0	365	$24	$0
GRP HOME II MOD SUPV	Days	23	$714,196	3	365	$95	$104,025	0	365	$146	$0	5	365	$57	$104,025	3	365	$28	$32,704	0	365	$24	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	0	$3,723	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	2	$24,017	1	365	$25	$9,125	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	5	$39,055	0	365	$25	$0	0	365	$30	$0	3	365	$25	$27,375	2	365	$20	$11,680	0	365	$15	$0
SPEC CARE I FAMILY	Days	2	$11,680	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	2	365	$20	$11,680	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	9	$31,009	1	365	$10	$3,699	0	365	$10	$0	2	365	$10	$7,397	2	365	$10	$5,918	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	17	$130,704	2	240	$31	$14,880	0	240	$30	$0	2	240	$23	$11,040	1	240	$20	$3,840	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	17	$98,928	2	240	$31	$11,160	0	240	$30	$0	5	240	$23	$27,600	6	240	$20	$30,720	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	0	$0	0	240	$26	$0	0	240	$30	$0	0	240	$22	$0	0	240	$19	$0	0	240	$17	$0
HOME-BASED TRAINING	Hours	9	$85,600	2	600	$16	$14,400	0	700	$16	$0	3	600	$16	$28,800	1	500	$16	$6,400	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	14	$57,000	2	113	$33	$6,242	0	164	$33	$0	2	141	$33	$11,378	3	152	$33	$13,242	0	176	$33	$0
PHYSICAL THERAPY	Hours	15	$23,403	2	47	$33	$2,713	0	47	$33	$0	5	47	$33	$6,977	1	47	$33	$2,114	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	28	$25	$0	0	80	$25	$0	0	37	$25	$0	0	35	$25	$0	0	46	$25	$0
CRISES INTERVENTION	Client	0	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	13	$118,401	1	263	$35	$11,500	0	394	$35	$0	2	197	$35	$12,834	1	263	$35	$11,040	0	329	$35	$0
PSYCHO- THERAPY	Hours	1	$300	0	40	$8	$32	0	72	$8	$0	0	36	$8	$58	0	48	$8	$31	0	60	$8	$0
PERSONAL CARE SVCS	Visit	9	$41,895	1	75	$57	$4,275	0	150	$57	$0	2	75	$57	$8,550	2	50	$57	$4,560	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	43	$7,100	5	1	$150	$750	0	1	$200	$0	10	1	$125	$1,250	8	1	$100	$800	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
ACUTE CARE	Client	49	$392,000	5	1	$8,000	$40,000	0	1	$8,000	$0	10	1	$8,000	$80,000	8	1	$8,000	$64,000	0	1	$8,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	49	$12,120	5	0.76	$175	$648	0	0.00	$0	$0	10	0.64	$151	$962	0	1.35	$318	$3,426	0	0.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	4	$4,360	1	28	$40	$560	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	20	$40	$0
LEVEL II RESPITE	Days	3	$2,079	1	21	$30	$315	0	21	$30	$0	2	21	$30	$1,260	1	21	$30	$504	0	21	$30	$0
LEVEL I RESPITE	Days	1	$420	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	1	21	$25	$420	0	21	$25	$0

TABLE F.9
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, AGES 6-21
WAIVER STRATEGY

YEAR 6

		ALL(1-10)		1 MED/PHYS OVRDG SKLIV				2 BEH-OVRDG SKLIV				3 CHRONIC&OTHER SKLIV				4 BEH-OVRDG SKLIII				5 CHRONIC SKLIII			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	40	$4,960	3	1	$124	$372	1	1	$124	$124	0	1	$124	$0	3	1	$124	$372	14	1	$124	$1,736
INDIV PLNG & MONITORING	Hours	40	$57,400	3	41	$35	$4,305	1	41	$35	$1,435	0	41	$35	$0	3	41	$35	$4,305	14	41	$35	$20,090
CLUSTER MANAGEMENT	Client	40	$60,000	3	1	$1,500	$4,500	1	1	$1,500	$1,500	0	1	$1,500	$0	3	1	$1,500	$4,500	14	1	$1,500	$21,000
ICF-MR IVA MEDCL SUPV	Days	3	$221,190	3	365	$202	$221,190	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	1	$81,030	0	365	$202	$0	1	365	$222	$81,030	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	6	$348,210	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	3	365	$172	$188,340	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	4	$40,080	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	20	$629,352	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	11	365	$109	$445,392
GRP HOME I MIN SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$3,066	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$3,066
SPEC CARE IIIFAMILY	Days	2	$13,914	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$12,264
SPEC CARE II FAMILY	Days	4	$30,470	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	1	$9,125	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	3	$11,096	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	1	365	$10	$5,170
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$30	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$30	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$30	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	2	$9,406	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	8	$71,360	0	600	$16	$0	0	600	$16	$0	0	600	$16	$0	0	700	$16	$0	3	600	$16	$26,000
SPCH & HRNG THERAPY	Hours	0	$0	0	42	$30	$0	0	84	$33	$0	0	70	$33	$0	0	129	$33	$0	0	113	$33	$0
PHYSICAL THERAPY	Hours	0	$0	0	70	$30	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	16	$30	$0	0	16	$25	$0	0	32	$25	$0	0	43	$25	$0	0	32	$25	$0
CRISES INTERVENTION	Client	5	$721	0	1	$156	$0	0	1	$156	$25	0	1	$156	$0	1	1	$156	$94	2	1	$156	$240
BEHAVIORAL CONSULTA:ION	Hours	14	$141,669	0	131	$35	$0	0	394	$35	$0	0	263	$35	$0	3	394	$35	$41,400	4	219	$35	$34,347
PSYCHO- THERAPY	Hours	1	$521	0	24	$8	$0	0	72	$8	$0	0	24	$8	$0	0	72	$8	$173	0	32	$8	$72
PERSONAL CARE SVCS	Visit	3	$14,108	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	1	190	$57	$7,900
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	36	$6,325	0	1	$600	$0	0	1	$400	$0	0	1	$300	$0	3	1	$300	$900	14	1	$200	$2,800
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	40	$80,000	3	1	$2,000	$6,000	1	1	$2,000	$2,000	0	1	$2,000	$0	3	1	$2,000	$6,000	14	1	$2,000	$28,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	40	$11,818	3	11.50	$355	$1,598	1	11.63	$385	$625	0	10.00	$0	$0	3	11.63	$385	$1,875	14	10.92	$210	$2,805
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	2	$1,600	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	1	28	$40	$1,360
LEVEL II RESPITE	Days	1	$736	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$150	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.9 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, AGES 6-21
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL		6 OTHER SKL				7 BEH-BVRDS SKL				8 CHRONIC SKL				9 OTHER SKL				10 OTHER SKL			
		INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	40	$4,960	2	1	$124	$248	3	1	$124	$372	9	1	$124	$1,116	4	1	$124	$496	1	1	$124	$124
INDIV PLNG & MONITORING	Hours	40	$57,400	2	41	$35	$2,870	3	41	$35	$4,305	9	41	$35	$12,915	4	41	$35	$5,740	1	41	$35	$1,435
CLUSTER MANAGEMENT	Client	40	$60,000	2	1	$1,500	$3,000	3	1	$1,500	$4,500	9	1	$1,500	$13,500	4	1	$1,500	$6,000	1	1	$1,500	$1,500
ICF-MR IVA MEDCL SUPV	Days	3	$221,190	0	365	$127	$0	0	365	$106	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	1	$81,030	0	365	$127	$0	0	365	$106	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$106	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	6	$340,210	0	365	$95	$0	3	365	$146	$159,870	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	4	$40,880	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	4	365	$28	$40,880	0	365	$24	$0
GRP HOME II MOD SUPV	Days	20	$629,352	1	365	$95	$40,345	0	365	$146	$0	5	365	$57	$112,347	2	365	$28	$20,440	0	365	$24	$2,620
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$28	$0	0	365	$24	$0
MED CARE III FAMILY	Days	0	$3,066	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	2	$15,914	0	365	$25	$3,650	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	4	$30,470	0	365	$25	$0	0	365	$30	$0	3	365	$25	$24,638	1	365	$20	$5,840	0	365	$15	$0
SPEC CARE I FAMILY	Days	1	$9,125	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	1	365	$20	$5,840	1	365	$15	$3,285
INDEPENDENT W/RELATIVES	Days	3	$11,096	0	365	$10	$740	0	365	$10	$0	1	365	$10	$3,329	0	365	$10	$1,479	0	365	$10	$370
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	2	$9,406	0	240	$24	$0	0	240	$30	$0	1	240	$22	$4,698	1	240	$19	$3,600	0	240	$17	$1,100
HOME-BASED TRAINING	Hours	8	$71,360	1	600	$16	$5,760	0	700	$16	$0	3	600	$16	$25,920	1	500	$16	$9,600	0	500	$16	$3,200
SPCH & HRNG THERAPY	Hours	0	$0	0	113	$33	$0	0	164	$33	$0	0	141	$33	$0	0	152	$33	$0	0	176	$33	$0
PHYSICAL THERAPY	Hours	0	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0	0	47	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	20	$25	$0	0	80	$25	$0	0	37	$25	$0	0	35	$25	$0	0	41	$25	$0
CRISES INTERVENTION	Client	5	$721	0	1	$156	$9	1	1	$156	$154	1	1	$156	$183	0	1	$156	$12	0	1	$156	$3
BEHAVIORAL CONSULTATION	Hours	14	$141,669	1	263	$35	$4,600	3	394	$35	$41,400	2	197	$35	$11,351	1	263	$35	$5,520	0	329	$35	$2,052
PSYCHO- THERAPY	Hours	1	$521	0	40	$8	$13	0	72	$8	$173	0	36	$8	$52	0	40	$8	$15	0	60	$8	$24
PERSONAL CARE SVCS	Visit	3	$14,108	0	75	$57	$855	0	150	$57	$0	1	75	$57	$3,040	0	50	$57	$1,140	0	50	$57	$285
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	36	$6,325	2	1	$150	$300	3	1	$200	$600	9	1	$125	$1,125	4	1	$100	$400	1	1	$200	$200
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
ACUTE CARE	Client	40	$80,000	2	1	$2,000	$4,000	3	1	$2,000	$6,000	9	1	$2,000	$18,000	4	1	$2,000	$8,000	1	1	$2,000	$2,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	40	$11,818	2	0.83	$196	$326	3	1.38	$325	$1,343	9	0.71	$168	$1,079	4	1.44	$341	$1,960	1	0.94	$222	$208
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	2	$1,600	0	20	$40	$112	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0
LEVEL II RESPITE	Days	1	$756	0	21	$30	$63	0	21	$30	$0	1	21	$30	$567	0	21	$30	$126	0	21	$30	$0
LEVEL I RESPITE	Days	0	$158	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$105	0	21	$25	$53

TABLE F.10
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, AGES 22+
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	INDIV #	ALL(1-10) TOTAL COST	1 MED/PHYS OVRDG SKLIV INDIV #	UNIT #	UNIT COST	TOTAL COST	2 BEH-OVRDG SKLIV INDIV #	UNIT #	UNIT COST	TOTAL COST	3 CHRONIC&OTHER SKLIV INDIV #	UNIT #	UNIT COST	TOTAL COST	4 BEH-OVRDG SKLIII INDIV #	UNIT #	UNIT COST	TOTAL COST	5 CHRONIC SKLIII INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	287	$35,588	15	1	$124	$1,860	3	1	$124	$372	27	1	$124	$3,348	6	1	$124	$744	54	1	$124	$6,696
INDIV PLNG & MONITORING	Hours	287	$411,845	15	41	$35	$21,525	3	41	$35	$4,305	27	41	$35	$38,745	6	41	$35	$8,610	54	41	$35	$77,490
CLUSTER MANAGEMENT	Client	287	$430,500	15	1	$1,500	$22,500	3	1	$1,500	$4,500	27	1	$1,500	$40,500	6	1	$1,500	$9,000	54	1	$1,500	$81,000
ICF-MR IVA MEDCL SUPV	Days	15	$1,105,950	15	365	$202	$1,105,950	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	3	$243,090	0	365	$202	$0	3	365	$222	$243,090	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	11	$643,130	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	6	365	$172	$376,680	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	78	$1,310,516	0	365	$159	$0	0	365	$172	$0	22	365	$119	$938,196	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	73	$2,730,157	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	43	365	$109	$1,710,712
GRP HOME I MIN SUPV	Days	74	$1,223,042	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	3	$39,130	0	365	$35	$0	0	365	$40	$0	3	365	$30	$39,130	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	2	$23,652	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	2	365	$30	$23,652
SPEC CARE IIIFAMILY	Days	21	$209,383	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	9	365	$30	$94,608
SPEC CARE II FAMILY	Days	46	$392,740	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	15	$100,923	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	63	$572,832	0	240	$43	$0	0	240	$50	$0	22	240	$40	$207,360	6	240	$47	$67,680	27	240	$36	$233,280
SHELTERED WORK	Days	93	$706,176	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	27	240	$36	$233,280
INTEGRATED ADULT SVCS	Days	75	$502,464	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	33	$136,096	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	600	$16	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0
SPCH & HRNG THERAPY	Hours	85	$330,711	0	42	$30	$0	0	84	$33	$0	10	70	$33	$24,130	2	129	$33	$8,940	19	113	$33	$71,623
PHYSICAL THERAPY	Hours	92	$142,638	0	70	$30	$0	0	47	$33	$0	9	47	$33	$13,396	1	47	$33	$1,057	23	47	$33	$35,166
OCCUPATIONAL THERAPY	Hours	140	$120,259	0	16	$30	$0	0	16	$25	$0	14	32	$25	$11,220	4	43	$25	$4,017	33	32	$25	$28,050
CRISES INTERVENTION	Client	24	$3,671	0	1	$156	$0	0	1	$156	$75	2	1	$136	$337	1	1	$156	$187	6	1	$156	$927
BEHAVIORAL CONSULTATION	Hours	68	$617,072	0	131	$35	$0	0	394	$35	$0	5	263	$35	$49,600	6	394	$35	$82,800	17	219	$35	$132,400
PSYCHO- THERAPY	Hours	6	$2,148	0	24	$8	$0	0	72	$8	$0	1	24	$8	$207	1	72	$8	$346	1	32	$8	$276
PERSONAL CARE SVCS	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	269	$43,050	0	1	$600	$0	0	1	$400	$0	27	1	$300	$8,100	6	1	$300	$1,800	54	1	$200	$10,800
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	287	$143,500	15	1	$500	$7,500	3	1	$500	$1,500	27	1	$500	$13,500	6	1	$500	$3,000	54	1	$500	$27,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	202	$105,239	15	1.50	$355	$7,989	3	1.63	$385	$1,875	27	1.32	$312	$11,136	6	2.44	$577	$8,438	54	1.09	$258	$15,171
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0	0	20	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.10 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, AGES 22+
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIVI #	ALL TOTAL COST	6 OTHER SKL INDIVI #	6 OTHER SKL UNIT #	6 OTHER SKL UNIT COST	6 OTHER SKL TOTAL COST	7 BEH-DVMNG SKL INDIVI #	7 BEH-DVMNG SKL UNIT #	7 BEH-DVMNG SKL UNIT COST	7 BEH-DVMNG SKL TOTAL COST	8 CHRONIC SKL INDIVI #	8 CHRONIC SKL UNIT #	8 CHRONIC SKL UNIT COST	8 CHRONIC SKL TOTAL COST	9 OTHER SKL INDIVI #	9 OTHER SKL UNIT #	9 OTHER SKL UNIT COST	9 OTHER SKL TOTAL COST	10 OTHER SKL INDIVI #	10 OTHER SKL UNIT #	10 OTHER SKL UNIT COST	10 OTHER SKL TOTAL COST
DIAGNOSIS & EVALUATION	Client	207	$35,300	42	1	$124	$5,208	5	1	$124	$620	74	1	$124	$9,176	56	1	$124	$6,944	5	1	$124	$620
INDIV PLNG & MONITORING	Hours	207	$411,043	42	41	$35	$60,270	5	41	$35	$7,175	74	41	$35	$106,190	56	41	$35	$80,360	5	41	$35	$7,175
CLUSTER MANAGEMENT	Client	207	$430,500	42	1	$1,500	$63,000	5	1	$1,500	$7,500	74	1	$1,500	$111,000	56	1	$1,500	$84,000	5	1	$1,500	$7,500
ICF-MR IVA MEDCL SUPV	Days	15	$1,105,950	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	3	$243,090	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	11	$443,130	0	365	$95	$0	5	365	$146	$266,450	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	70	$1,310,316	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	56	365	$28	$572,320	0	365	$24	$0
GRP HOME II MOD SUPV	Days	73	$2,738,157	29	365	$95	$1,019,445	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME I MIN SUPV	Days	74	$1,223,042	0	365	$95	$0	0	365	$146	$0	44	365	$57	$923,742	28	365	$28	$286,160	2	365	$24	$13,100
SPEC CARE IV FAMILY	Days	3	$59,130	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	2	$23,652	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	21	$209,505	13	365	$25	$114,975	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	66	$392,740	0	365	$25	$0	0	365	$30	$0	30	365	$25	$270,100	17	365	$20	$122,640	0	365	$15	$0
SPEC CARE I FAMILY	Days	13	$100,925	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	11	365	$20	$81,760	4	365	$15	$19,163
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$25	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	63	$572,032	8	240	$32	$64,512	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	93	$706,176	21	240	$32	$161,280	4	240	$40	$38,400	30	240	$29	$206,016	11	240	$25	$67,200	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	75	$502,464	13	240	$32	$96,768	1	240	$40	$9,600	30	240	$29	$206,016	31	240	$25	$184,800	1	240	$22	$5,200
SUPPORTED EMPLOYMENT	Days	33	$136,096	0	240	$24	$0	0	240	$30	$0	13	240	$22	$77,256	14	240	$19	$63,000	4	240	$17	$15,840
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0	0	500	$16	$0	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	83	$350,711	14	113	$33	$52,430	2	164	$33	$10,999	18	141	$33	$84,198	18	152	$33	$92,693	1	176	$33	$5,609
PHYSICAL THERAPY	Hours	92	$142,630	15	47	$33	$22,793	1	47	$33	$2,093	33	47	$33	$51,632	10	47	$33	$14,796	1	47	$33	$1,706
OCCUPATIONAL THERAPY	Hours	140	$120,259	22	28	$25	$13,272	2	80	$25	$3,247	50	37	$25	$46,340	13	35	$25	$11,555	1	41	$25	$559
CRISES INTERVENTION	Client	24	$3,671	1	1	$156	$197	2	1	$156	$257	10	1	$156	$1,501	1	1	$156	$175	0	1	$156	$16
BEHAVIORAL CONSULTATION	Hours	68	$617,072	11	263	$33	$96,600	3	394	$33	$69,000	14	197	$33	$94,972	8	263	$33	$77,200	1	329	$33	$10,260
PSYCHO- THERAPY	Hours	6	$2,140	1	40	$8	$269	1	72	$8	$200	1	36	$8	$426	1	40	$8	$215	0	60	$8	$120
PERSONAL CARE SVCS	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	30	$57	$0	0	30	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	269	$43,850	42	1	$150	$6,300	5	1	$200	$1,000	74	1	$125	$9,250	56	1	$100	$5,600	5	1	$200	$1,000
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	30	$57	$0	0	30	$57	$0
ACUTE CARE	Client	207	$143,500	42	1	$500	$21,000	5	1	$500	$2,500	74	1	$500	$37,000	56	1	$500	$28,000	5	1	$500	$2,500
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	202	$103,239	42	1.01	$239	$10,140	5	2.20	$521	$3,720	74	0.85	$200	$12,523	56	1.56	$369	$32,232	0	1.35	$320	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	20	$40	$0	0	20	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0

TABLE F.11
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, ALL AGES
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	INDIV #	ALL(1-10) TOTAL COST	1 MED/PHYS OVRDG SKL1				2 BEH-OVRDG SKL1				3 CHRONIC&OTHER SKL1				4 BEH-OVRDG SKL2				5 CHRONIC SKL2			
				INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	376	$46,624	24	1	$124	$2,976	4	1	$124	$496	27	1	$124	$3,340	12	1	$124	$1,488	85	1	$124	$10,540
INDIV PLNG & MONITORING	Hours	376	$539,560	24	41	$35	$34,440	4	41	$35	$5,740	27	41	$35	$38,745	12	41	$35	$17,220	85	41	$35	$121,975
CLUSTER MANAGEMENT	Client	376	$564,000	24	1	$1,500	$36,000	4	1	$1,500	$6,000	27	1	$1,500	$40,500	12	1	$1,500	$18,000	85	1	$1,500	$127,500
ICF-MR IVA MEDCL SUPV	Days	24	$1,769,520	24	365	$202	$1,769,520	0	0	$222	$0	0	0	$159	$0	0	0	$219	$0	0	0	$143	$0
ICF-MR IVB BEHVR MGMT	Days	4	$324,120	0	0	$202	$0	4	365	$222	$324,120	0	0	$159	$0	0	0	$219	$0	0	0	$143	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$202	$0	0	0	$222	$0	0	0	$159	$0	0	0	$219	$0	0	0	$143	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$159	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
GRP HOME IVB BEHVR MGMT	Days	19	$1,142,012	0	0	$159	$0	0	0	$172	$0	0	0	$119	$0	11	365	$172	$715,692	0	0	$109	$0
GRP HOME III HIGH SUPV	Days	90	$1,633,136	0	0	$159	$0	0	0	$172	$0	22	365	$119	$938,196	0	0	$172	$0	0	0	$109	$0
GRP HOME II MOD SUPV	Days	116	$4,001,905	0	0	$159	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	66	365	$109	$2,637,746
GRP HOME I MIN SUPV	Days	74	$1,223,042	0	0	$159	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
SPEC CARE IV FAMILY	Days	3	$39,130	0	0	$35	$0	0	0	$40	$0	5	365	$30	$39,130	0	0	$35	$0	0	0	$30	$0
MED CARE III FAMILY	Days	3	$30,441	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	3	365	$30	$30,441
SPEC CARE IIIFAMILY	Days	23	$249,314	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	11	365	$30	$121,764
SPEC CARE II FAMILY	Days	33	$462,273	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	0	0	$30	$0
SPEC CARE I FAMILY	Days	10	$121,720	0	0	$35	$0	0	0	$40	$0	0	0	$30	$0	0	0	$35	$0	0	0	$30	$0
INDEPENDENT W/RELATIVES	Days	12	$42,905	0	0	$10	$0	0	0	$10	$0	0	0	$10	$0	1	365	$10	$2,219	5	365	$10	$17,754
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	17	$130,704	0	0	$38	$0	0	0	$36	$0	0	0	$31	$0	2	240	$35	$20,160	10	240	$33	$80,784
INTEGRATED INF ST/PRE-SC	Days	17	$90,920	0	0	$38	$0	0	0	$36	$0	0	0	$31	$0	0	240	$33	$2,520	3	240	$33	$26,928
WORK ACTIVITY	Days	63	$572,032	0	0	$43	$0	0	0	$30	$0	22	240	$40	$207,360	6	240	$47	$67,680	27	240	$36	$233,280
SHELTERED WORK	Days	93	$706,176	0	0	$43	$0	0	0	$30	$0	0	0	$40	$0	0	0	$47	$0	27	240	$36	$233,280
INTEGRATED ADULT SVCS	Days	75	$502,464	0	0	$43	$0	0	0	$30	$0	0	0	$40	$0	0	0	$47	$0	0	0	$36	$0
SUPPORTED EMPLOYMENT	Days	33	$165,382	0	0	$32	$0	0	0	$38	$0	0	0	$30	$0	0	0	$35	$0	0	0	$27	$0
HOME-BASED TRAINING	Hours	17	$136,960	0	0	$16	$0	0	0	$16	$0	0	0	$16	$0	0	700	$16	$5,360	6	600	$16	$59,520
SPCH & HRNG THERAPY	Hours	99	$400,590	0	0	$30	$0	0	0	$33	$0	10	70	$33	$24,138	3	129	$33	$13,410	25	113	$33	$94,172
PHYSICAL THERAPY	Hours	107	$166,042	0	0	$30	$0	0	0	$33	$0	9	47	$33	$13,396	1	47	$33	$1,385	30	47	$33	$46,236
OCCUPATIONAL THERAPY	Hours	100	$120,239	0	0	$30	$0	0	0	$25	$0	14	32	$25	$11,220	4	41	$25	$4,017	35	32	$25	$28,050
CRISES INTERVENTION	Client	28	$4,391	0	0	$136	$0	1	1	$136	$100	2	1	$136	$337	2	1	$136	$281	7	1	$136	$1,167
BEHAVIORAL CONSULTATION	Hours	94	$877,222	0	0	$35	$0	0	0	$33	$0	5	263	$35	$49,680	12	394	$35	$165,600	27	219	$35	$208,333
PSYCHO- THERAPY	Hours	9	$3,019	0	0	$8	$0	0	0	$8	$0	1	24	$8	$207	1	72	$8	$691	2	32	$8	$435
PERSONAL CARE SVCS	Visit	12	$36,003	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	1	130	$57	$3,130	5	100	$57	$27,360
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	340	$37,275	0	0	$600	$0	0	0	$400	$0	27	1	$300	$8,100	12	1	$300	$3,600	85	1	$200	$17,000
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	376	$613,500	24	1	$2,750	$61,500	4	1	$2,750	$3,500	27	1	$500	$13,500	12	1	$2,750	$33,000	85	1	$2,750	$191,000
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	375	$129,178	24	2	$355	$12,782	4	2	$385	$2,500	27	1	$312	$11,136	12	2	$492	$11,313	85	1	$235	$20,665
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0
LEVEL III RESPITE	Days	5	$6,040	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	5	28	$40	$5,376
LEVEL II RESPITE	Days	5	$2,835	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0
LEVEL I RESPITE	Days	1	$570	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0

TABLE F.11 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
METROPOLITAN AREA WAITING LISTS, ALL AGES
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIV #	ALL TOTAL COST	6 OTHER SIL2 INDIV #	6 OTHER SIL2 UNIT #	6 OTHER SIL2 UNIT COST	6 OTHER SIL2 TOTAL COST	7 BEH-OVRDG SIL3 INDIV #	7 BEH-OVRDG SIL3 UNIT #	7 BEH-OVRDG SIL3 UNIT COST	7 BEH-OVRDG SIL3 TOTAL COST	8 CHRONIC SIL3 INDIV #	8 CHRONIC SIL3 UNIT #	8 CHRONIC SIL3 UNIT COST	8 CHRONIC SIL3 TOTAL COST	9 OTHER SIL3 INDIV #	9 OTHER SIL3 UNIT #	9 OTHER SIL3 UNIT COST	9 OTHER SIL3 TOTAL COST	10 OTHER SIL4 INDIV #	10 OTHER SIL4 UNIT #	10 OTHER SIL4 UNIT COST	10 OTHER SIL4 TOTAL COST
DIAGNOSIS & EVALUATION	Client	376	$46,624	49	1	$124	$6,076	8	1	$124	$992	93	1	$124	$11,532	68	1	$124	$8,432	6	1	$124	$744
INDIV PLNG & MONITORING	Hours	376	$539,560	49	41	$35	$70,315	8	41	$35	$11,480	93	41	$35	$133,455	68	41	$35	$97,580	6	41	$35	$8,610
CLUSTER MANAGEMENT	Client	376	$564,000	49	1	$1,500	$73,500	8	1	$1,500	$12,000	93	1	$1,500	$139,500	68	1	$1,500	$102,000	6	1	$1,500	$9,000
ICF-MR IVA MEDCL SUPV	Days	24	$1,769,520	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
ICF-MR IVB BEHVR MGMT	Days	4	$324,120	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$95	$0	0	0	$146	$0	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME IVB BEHVR MGMT	Days	19	$1,142,012	0	0	$95	$0	8	365	$146	$426,320	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME III HIGH SUPV	Days	90	$1,633,136	0	0	$95	$0	0	0	$146	$0	0	0	$57	$0	68	365	$28	$694,960	0	0	$24	$0
GRP HOME II MOD SUPV	Days	116	$4,081,905	34	365	$95	$1,172,015	0	0	$146	$0	10	365	$57	$216,372	5	365	$28	$53,144	0	365	$24	$2,620
GRP HOME I MIN SUPV	Days	74	$1,223,042	0	0	$95	$0	0	0	$146	$0	44	365	$57	$923,742	28	365	$28	$286,160	2	365	$24	$13,140
SPEC CARE IV FAMILY	Days	5	$39,130	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
MED CARE III FAMILY	Days	3	$30,441	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
SPEC CARE IIIFAMILY	Days	25	$249,314	14	365	$25	$127,750	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
SPEC CARE II FAMILY	Days	55	$462,273	0	0	$25	$0	0	0	$30	$0	35	365	$25	$322,113	19	365	$20	$140,160	0	0	$15	$0
SPEC CARE I FAMILY	Days	18	$121,720	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	14	365	$20	$99,200	4	365	$15	$22,440
INDEPENDENT W/RELATIVES	Days	12	$42,905	1	365	$10	$4,438	0	0	$10	$0	3	365	$10	$10,726	2	365	$10	$7,397	0	365	$10	$370
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	17	$130,704	2	240	$31	$14,880	0	0	$30	$0	2	240	$23	$11,040	1	240	$20	$3,840	0	0	$19	$0
INTEGRATED INF ST/PRE-SC	Days	17	$98,920	2	240	$31	$11,160	0	0	$30	$0	5	240	$23	$27,600	6	240	$20	$30,720	0	0	$19	$0
WORK ACTIVITY	Days	63	$572,032	8	240	$32	$64,512	0	0	$40	$0	0	0	$29	$0	0	0	$25	$0	0	0	$22	$0
SHELTERED WORK	Days	93	$706,176	21	240	$32	$161,280	4	240	$40	$38,400	30	240	$29	$206,016	11	240	$25	$67,200	0	0	$22	$0
INTEGRATED ADULT SVCS	Days	75	$502,464	13	240	$32	$96,768	1	240	$40	$9,600	30	240	$29	$206,016	31	240	$25	$184,000	1	240	$22	$5,280
SUPPORTED EMPLOYMENT	Days	35	$163,302	0	0	$24	$0	0	0	$30	$0	16	240	$22	$81,934	13	240	$19	$66,600	4	240	$17	$17,028
HOME-BASED TRAINING	Hours	17	$136,960	2	600	$16	$20,160	0	0	$16	$0	6	600	$16	$54,720	2	500	$16	$16,000	0	500	$16	$3,200
SPCH & HRNG THERAPY	Hours	99	$400,390	16	113	$33	$50,672	2	160	$33	$10,999	21	141	$33	$95,376	21	152	$33	$105,335	1	176	$33	$5,609
PHYSICAL THERAPY	Hours	107	$166,042	16	47	$33	$25,306	1	47	$33	$2,093	38	47	$33	$58,609	11	47	$33	$16,909	1	47	$33	$1,706
OCCUPATIONAL THERAPY	Hours	140	$120,259	22	28	$25	$15,272	2	80	$25	$3,247	50	37	$25	$46,340	13	35	$25	$11,355	1	41	$25	$559
CRISES INTERVENTION	Client	28	$4,391	1	1	$156	$206	3	1	$156	$412	11	1	$156	$1,683	1	1	$156	$107	0	1	$156	$19
BEHAVIORAL CONSULTATION	Hours	94	$877,222	12	263	$35	$112,700	8	394	$35	$110,404	17	197	$35	$119,356	10	263	$35	$93,040	1	329	$35	$17,112
PSYCHO- THERAPY	Hours	9	$3,049	1	40	$8	$314	1	72	$8	$461	2	36	$8	$536	1	40	$8	$261	0	60	$8	$144
PERSONAL CARE SVCS	Visit	12	$36,003	1	73	$57	$3,130	0	0	$57	$0	3	75	$57	$12,398	2	50	$57	$5,700	0	30	$57	$285
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	348	$57,275	49	1	$150	$7,350	8	1	$200	$1,600	93	1	$125	$11,625	68	1	$100	$6,800	6	1	$200	$1,200
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	376	$615,500	49	1	$2,750	$65,000	8	1	$2,750	$8,500	93	1	$2,750	$135,000	68	1	$2,750	$100,000	6	1	$2,750	$4,500
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	371	$129,178	49	1	$216	$11,123	8	2	$446	$7,071	93	1	$182	$14,564	68	2	$351	$37,617	1	1	$200	$208
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0	0	0	$50	$0
LEVEL III RESPITE	Days	5	$6,048	1	28	$40	$672	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0
LEVEL II RESPITE	Days	5	$2,835	1	21	$30	$378	0	0	$30	$0	3	21	$30	$1,827	1	21	$30	$630	0	0	$30	$0
LEVEL I RESPITE	Days	1	$578	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	1	21	$25	$525	0	21	$25	$53

TABLE F.12
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, AGES 0-5
WAIVER STRATEGY

YEAR 0

		ALL(1-10)		1 MED/PHYS OVRDG SKLIV				2 BEH-OVRDG SKLIV				3 CHRONIC&OTHER SKLIV				4 BEH-OVRDG SKLIII				5 CHRONIC SKLIII			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	11	$1,364	3	1	$124	$372	0	1	$124	$0	2	1	$124	$248	0	1	$124	$0	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	11	$15,785	3	41	$35	$4,305	0	41	$35	$0	2	41	$35	$2,870	0	41	$35	$0	0	41	$35	$0
CLUSTER MANAGEMENT	Client	11	$16,500	3	1	$1,500	$4,500	0	1	$1,500	$0	2	1	$1,500	$3,000	0	1	$1,500	$0	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	3	$221,190	3	365	$202	$221,190	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$139	$0	0	365	$219	$0	0	365	$145	$0
GAP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GAP HOME IVB BEHVR MGMT	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GAP HOME III HIGH SUPV	Days	3	$81,249	0	365	$139	$0	0	365	$172	$0	1	365	$119	$60,009	0	365	$172	$0	0	365	$109	$0
GAP HOME II MOD SUPV	Days	3	$70,391	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GAP HOME I MIN SUPV	Days	0	$0	0	365	$139	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	0	$2,190	0	365	$35	$0	0	365	$40	$0	0	365	$30	$2,190	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$0	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE IIIFAMILY	Days	0	$3,650	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE II FAMILY	Days	1	$8,395	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	0	$2,920	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	2	$5,910	0	365	$10	$0	0	365	$10	$0	0	365	$10	$1,479	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	3	$19,336	0	240	$38	$0	0	240	$36	$0	1	240	$31	$10,416	0	240	$33	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	3	$19,152	0	240	$38	$0	0	240	$36	$0	0	240	$31	$1,488	0	240	$33	$0	0	240	$33	$0
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	0	$0	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	2	$16,960	0	600	$16	$0	0	600	$16	$0	0	600	$16	$3,840	0	700	$16	$0	0	600	$16	$0
SPCH & HRNG THERAPY	Hours	3	$8,417	0	36	$30	$0	0	72	$33	$0	1	60	$33	$1,325	0	110	$33	$0	0	96	$33	$0
PHYSICAL THERAPY	Hours	3	$4,000	0	48	$30	$0	0	48	$33	$0	1	48	$33	$1,014	0	48	$33	$0	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	12	$30	$0	0	12	$25	$0	0	24	$25	$0	0	32	$25	$0	0	24	$25	$0
CRISES INTERVENTION	Client	0	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	2	$8,262	0	80	$35	$0	0	239	$35	$0	0	160	$35	$2,234	0	239	$35	$0	0	133	$35	$0
PSYCHO- THERAPY	Hours	0	$47	0	24	$8	$0	0	72	$8	$0	0	24	$8	$15	0	72	$8	$0	0	32	$8	$0
PERSONAL CARE SVCS	Visit	2	$9,120	0	250	$57	$0	0	250	$57	$0	0	200	$57	$4,360	0	150	$57	$0	0	100	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0	0	1	$1,800	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	0	$1,350	0	1	$600	$0	0	1	$400	$0	2	1	$300	$600	0	1	$300	$0	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	11	$88,000	3	1	$8,000	$24,000	0	1	$8,000	$0	2	1	$8,000	$16,000	0	1	$8,000	$0	0	1	$8,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	11	$3,279	3	1.30	$355	$1,398	0	0.00	$0	$0	2	0.89	$210	$373	0	0.00	$0	$0	0	0.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$600	0	30	$50	$0	0	30	$50	$0	0	30	$50	$600	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$224	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	1	$504	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$105	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.12 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, AGES 0-5
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL INDIV #	ALL TOTAL COST	6 OTHER SKL INDIV #	6 OTHER SKL UNIT #	6 OTHER SKL UNIT COST	6 OTHER SKL TOTAL COST	7 BEH-DVRDG SKL INDIV #	7 BEH-DVRDG SKL UNIT #	7 BEH-DVRDG SKL UNIT COST	7 BEH-DVRDG SKL TOTAL COST	8 CHRONIC SKL INDIV #	8 CHRONIC SKL UNIT #	8 CHRONIC SKL UNIT COST	8 CHRONIC SKL TOTAL COST	9 OTHER SKL INDIV #	9 OTHER SKL UNIT #	9 OTHER SKL UNIT COST	9 OTHER SKL TOTAL COST	10 OTHER SKL INDIV #	10 OTHER SKL UNIT #	10 OTHER SKL UNIT COST	10 OTHER SKL TOTAL COST
DIAGNOSIS & EVALUATION	Client	11	$1,364	2	1	$124	$248	0	1	$124	$0	2	1	$124	$248	2	1	$124	$248	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	11	$15,785	2	41	$35	$2,870	0	41	$35	$0	2	41	$35	$2,870	2	41	$35	$2,870	0	41	$35	$0
CLUSTER MANAGEMENT	Client	11	$16,500	2	1	$1,500	$3,000	0	1	$1,500	$0	2	1	$1,500	$3,000	2	1	$1,500	$3,000	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	3	$221,190	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$55	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$55	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	3	$81,249	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	2	365	$28	$20,440	0	365	$24	$0
GRP HOME II MOD SUPV	Days	3	$70,391	1	365	$95	$41,610	0	365	$146	$0	1	365	$57	$20,805	1	365	$28	$8,176	0	365	$24	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	0	$2,190	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	0	$0	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	0	$3,650	0	365	$25	$3,650	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	1	$8,395	0	365	$25	$0	0	365	$30	$0	1	365	$25	$5,475	0	365	$20	$2,920	0	365	$15	$0
SPEC CARE I FAMILY	Days	0	$2,920	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$2,920	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	2	$5,910	0	365	$10	$1,479	0	365	$10	$0	0	365	$10	$1,479	0	365	$10	$1,479	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	3	$19,536	1	240	$31	$5,952	0	240	$30	$0	0	240	$23	$2,208	0	240	$20	$960	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	3	$19,152	1	240	$31	$4,464	0	240	$30	$0	1	240	$23	$5,320	2	240	$20	$7,680	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	0	$0	0	240	$24	$0	0	240	$30	$0	0	240	$22	$0	0	240	$19	$0	0	240	$17	$0
HOME-BASED TRAINING	Hours	2	$16,960	1	600	$16	$5,760	0	700	$16	$0	1	600	$16	$5,760	0	500	$16	$1,600	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	3	$8,417	1	96	$33	$2,129	0	140	$33	$0	0	120	$33	$1,940	1	130	$33	$2,823	0	130	$33	$0
PHYSICAL THERAPY	Hours	3	$4,088	1	48	$33	$1,109	0	48	$33	$0	1	48	$33	$1,426	0	48	$33	$540	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	21	$25	$0	0	60	$25	$0	0	28	$25	$0	0	26	$25	$0	0	31	$25	$0
CRISES INTERVENTION	Client	0	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	2	$8,262	1	160	$35	$2,793	0	239	$35	$0	0	120	$35	$1,350	0	160	$35	$1,676	0	200	$35	$0
PSYCHO- THERAPY	Hours	0	$47	0	40	$8	$13	0	72	$8	$0	0	36	$8	$12	0	40	$8	$8	0	60	$8	$0
PERSONAL CARE SVCS	Visit	2	$7,120	0	75	$57	$1,710	0	150	$57	$0	0	75	$57	$1,710	0	30	$57	$1,140	0	50	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	8	$1,350	2	1	$150	$300	0	1	$200	$0	2	1	$125	$250	2	1	$100	$200	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	50	$57	$0	0	50	$57	$0
ACUTE CARE	Client	11	$88,000	2	1	$8,000	$16,000	0	1	$8,000	$0	2	1	$8,000	$16,000	2	1	$8,000	$16,000	0	1	$8,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	11	$3,279	2	0.74	$175	$259	0	0.00	$0	$0	2	0.64	$151	$192	2	1.35	$318	$856	0	0.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$600	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$224	0	28	$40	$224	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	1	$504	0	21	$30	$126	0	21	$30	$0	0	21	$30	$252	0	21	$30	$126	0	21	$30	$0
LEVEL I RESPITE	Days	0	$105	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$105	0	21	$25	$0

TABLE F.13
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, AGES 6-21
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	ALL(1-10) INDIV #	ALL(1-10) TOTAL COST	1 MED/PHYS OVRDG SKLIV INDIV #	UNIT #	UNIT COST	TOTAL COST	2 BEH-OVRDG SKLIV INDIV #	UNIT #	UNIT COST	TOTAL COST	3 CHRONIC&OTHER SKLIV INDIV #	UNIT #	UNIT COST	TOTAL COST	4 BEH-OVRDG SKLIII INDIV #	UNIT #	UNIT COST	TOTAL COST	5 CHRONIC SKLIII INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	65	$8,060	7	1	$124	$868	7	1	$124	$868	2	1	$124	$248	7	1	$124	$868	14	1	$124	$1,736
INDIV PLNG & MONITORING	Hours	65	$93,275	7	41	$35	$10,045	7	41	$35	$10,045	2	41	$35	$2,870	7	41	$35	$10,045	14	41	$35	$29,090
CLUSTER MANAGEMENT	Client	65	$97,500	7	1	$1,500	$10,500	7	1	$1,500	$10,500	2	1	$1,500	$3,000	7	1	$1,500	$10,500	14	1	$1,500	$21,000
ICF-MR IVA MEDCL SUPV	Days	7	$516,110	7	365	$202	$516,110	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	7	$567,210	0	365	$202	$0	7	365	$222	$567,210	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	13	$759,200	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	7	365	$172	$439,460	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	13	$181,916	0	365	$159	$0	0	365	$172	$0	2	365	$119	$69,496	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	24	$698,063	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	11	365	$109	$443,392
GRP HOME I MIN SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	0	$2,190	0	365	$35	$0	0	365	$40	$0	0	365	$30	$2,190	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	0	$3,066	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$3,066
SPEC CARE IIIFAMILY	Days	2	$21,389	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$12,264
SPEC CARE II FAMILY	Days	4	$32,485	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	2	$16,060	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	4	$14,035	0	365	$10	$0	0	365	$10	$0	0	365	$10	$740	0	365	$10	$0	1	365	$10	$3,170
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$30	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$30	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SHELTERED WORK	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	3	$13,032	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	10	$88,000	0	600	$16	$0	0	600	$16	$0	0	600	$16	$3,040	0	700	$16	$0	3	600	$16	$26,800
SPCH & HRNG THERAPY	Hours	0	$0	0	36	$30	$0	0	72	$33	$0	0	60	$33	$0	0	110	$33	$0	0	96	$33	$0
PHYSICAL THERAPY	Hours	0	$0	0	48	$30	$0	0	48	$33	$0	0	48	$33	$0	0	48	$33	$0	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	12	$30	$0	0	12	$25	$0	0	24	$25	$0	0	32	$25	$0	0	24	$25	$0
CRISES INTERVENTION	Client	7	$1,147	0	1	$156	$0	1	1	$156	$175	0	1	$156	$25	1	1	$156	$210	2	1	$156	$240
BEHAVIORAL CONSULTATION	Hours	22	$132,891	0	80	$35	$0	0	239	$33	$0	0	160	$35	$2,234	7	239	$35	$58,633	4	133	$35	$20,854
PSYCHO- THERAPY	Hours	2	$945	0	24	$8	$0	0	72	$8	$0	0	24	$8	$15	1	72	$8	$403	0	32	$8	$72
PERSONAL CARE SVCS	Visit	4	$18,098	0	250	$57	$0	0	250	$57	$0	0	200	$57	$2,280	0	150	$57	$0	1	100	$57	$7,900
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	31	$9,300	0	1	$600	$0	0	1	$400	$0	2	1	$300	$600	7	1	$300	$2,100	14	1	$200	$2,800
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	65	$130,000	7	1	$2,000	$14,000	7	1	$2,000	$14,000	2	1	$2,000	$4,000	7	1	$2,000	$14,000	14	1	$2,000	$28,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	65	$25,370	7	1.50	$355	$3,728	7	1.63	$385	$4,375	2	1.00	$237	$473	7	1.63	$385	$4,375	14	0.92	$210	$2,805
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$300	0	30	$50	$0	0	30	$50	$0	0	30	$50	$300	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	2	$1,040	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	1	28	$40	$1,360
LEVEL II RESPITE	Days	1	$882	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	1	$289	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.13 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, AGES 6-21
WAIVER STRATEGY

TYPE OF SERVICE	UNIT TYPE	ALL		6 OTHER SKL				7 BEH-OVRDG SKL				8 CHRONIC SKL				9 OTHER SKL				10 OTHER SKL			
		INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	65	$8,060	5	1	$124	$620	6	1	$124	$744	6	1	$124	$744	11	1	$124	$1,364	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	65	$93,275	5	41	$35	$7,175	6	41	$35	$8,610	6	41	$35	$8,610	11	41	$35	$15,785	0	41	$35	$0
CLUSTER MANAGEMENT	Client	65	$97,500	5	1	$1,500	$7,500	6	1	$1,500	$9,000	6	1	$1,500	$9,000	11	1	$1,500	$16,500	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	7	$316,110	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	7	$367,210	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	13	$739,200	0	365	$95	$0	6	365	$146	$319,740	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	13	$181,916	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	11	365	$28	$112,420	0	365	$24	$0
GRP HOME II MOD SUPV	Days	24	$690,063	4	365	$95	$121,363	0	365	$146	$0	4	365	$57	$74,898	6	365	$28	$56,210	0	365	$24	$0
GRP HOME I MIN SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
SPEC CARE IV FAMILY	Days	0	$2,190	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$24	$0
MED CARE III FAMILY	Days	0	$3,066	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	2	$21,389	1	365	$25	$9,125	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	4	$32,485	0	365	$25	$0	0	365	$30	$0	2	365	$25	$16,425	2	365	$20	$16,060	0	365	$15	$0
SPEC CARE I FAMILY	Days	2	$16,060	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	2	365	$20	$16,060	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	4	$14,055	1	365	$10	$1,049	0	365	$10	$0	1	365	$10	$2,219	1	365	$10	$4,069	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	0	$0	0	240	$32	$0	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	3	$13,032	0	240	$24	$0	0	240	$30	$0	1	240	$22	$3,132	2	240	$19	$9,900	0	240	$17	$0
HOME-BASED TRAINING	Hours	10	$80,000	2	600	$16	$14,400	0	700	$16	$0	2	600	$16	$17,200	3	500	$16	$26,400	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	0	$0	0	96	$33	$0	0	144	$33	$0	0	120	$33	$0	0	130	$33	$0	0	150	$33	$0
PHYSICAL THERAPY	Hours	0	$0	0	48	$33	$0	0	48	$33	$0	0	48	$33	$0	0	48	$33	$0	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	0	$0	0	21	$25	$0	0	60	$25	$0	0	20	$25	$0	0	26	$25	$0	0	31	$25	$0
CRISES INTERVENTION	Client	7	$1,147	0	1	$156	$23	2	1	$156	$309	1	1	$156	$122	0	1	$156	$34	0	1	$156	$0
BEHAVIORAL CONSULTATION	Hours	22	$132,891	1	160	$35	$6,983	6	239	$35	$50,274	1	120	$35	$4,675	2	160	$35	$9,217	0	200	$35	$0
PSYCHO- THERAPY	Hours	2	$945	0	48	$8	$32	1	72	$8	$346	0	36	$8	$35	0	48	$8	$42	0	60	$8	$0
PERSONAL CARE SVCS	Visit	4	$18,098	1	75	$57	$2,138	0	150	$57	$0	1	75	$57	$2,363	1	50	$57	$3,133	0	30	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	31	$9,300	5	1	$150	$750	6	1	$200	$1,200	6	1	$125	$750	11	1	$100	$1,100	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	30	$57	$0	0	30	$57	$0
ACUTE CARE	Client	65	$130,000	5	1	$2,000	$10,000	6	1	$2,000	$12,000	6	1	$2,000	$12,000	11	1	$2,000	$22,000	0	1	$2,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	65	$25,370	5	10.83	$196	$815	6	11.38	$325	$2,683	6	10.73	$172	$753	11	11.43	$240	$5,360	0	10.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$300	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	2	$1,040	0	28	$40	$200	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	1	$882	0	21	$30	$158	0	21	$30	$0	1	21	$30	$378	1	21	$30	$347	0	21	$30	$0
LEVEL I RESPITE	Days	1	$289	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	1	21	$25	$289	0	21	$25	$0

TABLE F.14
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, AGES 22+
WAIVER STRATEGY

YEAR 6

TYPE OF SERVICE	UNIT TYPE	ALL(1-16) INDIV #	ALL(1-16) TOTAL COST	1 MED/PHYS OVRDG SKLIV INDIV #	UNITS #	UNIT COST	TOTAL COST	2 BEH-OVRDG SKLIV INDIV #	UNITS #	UNIT COST	TOTAL COST	3 CHRONIC&OTHER SKLIV INDIV #	UNITS #	UNIT COST	TOTAL COST	4 BEH-OVRDG SKLIII INDIV #	UNITS #	UNIT COST	TOTAL COST	5 CHRONIC SKLIII INDIV #	UNITS #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	145	$17,980	5	1	$124	$620	3	1	$124	$372	15	1	$124	$1,860	10	1	$124	$1,240	28	1	$124	$3,472
INDIV PLNG & MONITORING	Hours	145	$200,075	5	41	$35	$7,175	3	41	$35	$4,305	15	41	$35	$21,525	10	41	$35	$14,350	28	41	$35	$40,180
CLUSTER MANAGEMENT	Client	145	$217,500	5	1	$1,500	$7,500	3	1	$1,500	$4,500	15	1	$1,500	$22,500	10	1	$1,500	$15,000	28	1	$1,500	$42,000
ICF-MR IVA MEDCL SUPV	Days	5	$368,650	5	365	$202	$368,650	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR IVB BEHVR MGMT	Days	3	$243,090	0	365	$202	$0	3	365	$222	$243,090	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$202	$0	0	365	$222	$0	0	365	$159	$0	0	365	$219	$0	0	365	$145	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
GRP HOME IVB BEHVR MGMT	Days	19	$1,107,410	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	10	365	$172	$627,800	0	365	$109	$0
GRP HOME III HIGH SUPV	Days	45	$850,400	0	365	$159	$0	0	365	$172	$0	12	365	$119	$521,220	0	365	$172	$0	0	365	$109	$0
GRP HOME II MOD SUPV	Days	35	$1,328,089	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	22	365	$109	$871,104
GRP HOME I MIN SUPV	Days	36	$468,222	0	365	$159	$0	0	365	$172	$0	0	365	$119	$0	0	365	$172	$0	0	365	$109	$0
SPEC CARE IV FAMILY	Days	3	$32,850	0	365	$35	$0	0	365	$40	$0	3	365	$30	$32,850	0	365	$35	$0	0	365	$30	$0
MED CARE III FAMILY	Days	1	$12,264	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	1	365	$30	$12,264
SPEC CARE IIIFAMILY	Days	10	$98,331	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	4	365	$30	$49,036
SPEC CARE II FAMILY	Days	20	$139,870	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
SPEC CARE I FAMILY	Days	7	$98,100	0	365	$35	$0	0	365	$40	$0	0	365	$30	$0	0	365	$35	$0	0	365	$30	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
INTEGRATED INF ST/PRE-SC	Days	0	$0	0	240	$38	$0	0	240	$36	$0	0	240	$31	$0	0	240	$35	$0	0	240	$33	$0
WORK ACTIVITY	Days	40	$376,608	0	240	$43	$0	0	240	$50	$0	12	240	$40	$115,200	10	240	$47	$112,800	14	240	$36	$120,960
SHELTERED WORK	Days	46	$365,616	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	14	240	$36	$120,960
INTEGRATED ADULT SVCS	Days	33	$234,460	0	240	$43	$0	0	240	$50	$0	0	240	$40	$0	0	240	$47	$0	0	240	$36	$0
SUPPORTED EMPLOYMENT	Days	13	$62,101	0	240	$32	$0	0	240	$38	$0	0	240	$30	$0	0	240	$35	$0	0	240	$27	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	600	$16	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0
SPCH & HRNG THERAPY	Hours	46	$161,710	0	36	$30	$0	0	72	$33	$0	6	60	$33	$11,435	4	110	$33	$12,705	10	96	$33	$31,667
PHYSICAL THERAPY	Hours	43	$67,073	0	48	$30	$0	0	48	$33	$0	5	48	$33	$7,603	1	48	$33	$1,799	12	48	$33	$18,620
OCCUPATIONAL THERAPY	Hours	68	$46,182	0	12	$36	$0	0	12	$25	$0	8	24	$25	$4,666	6	32	$25	$5,011	10	24	$25	$10,006
CRISES INTERVENTION	Client	14	$2,192	0	1	$156	$0	0	1	$156	$75	1	1	$156	$107	2	1	$156	$312	3	1	$156	$480
BEHAVIORAL CONSULTATION	Hours	45	$289,157	0	80	$35	$0	0	239	$35	$0	3	160	$35	$16,738	10	239	$35	$83,790	9	133	$35	$41,709
PSYCHO- THERAPY	Hours	4	$1,733	0	24	$8	$0	0	72	$8	$0	1	24	$8	$115	1	72	$8	$576	1	32	$8	$143
PERSONAL CARE SVCS	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	137	$23,900	0	1	$600	$0	0	1	$400	$0	15	1	$300	$4,500	10	1	$300	$3,000	28	1	$200	$5,600
HOME HEALTH SERVICES	Visit	0	$0	0	250	$57	$0	0	250	$57	$0	0	200	$57	$0	0	150	$57	$0	0	100	$57	$0
ACUTE CARE	Client	145	$72,500	5	1	$500	$2,500	3	1	$500	$1,500	15	1	$500	$7,500	10	1	$500	$5,000	28	1	$500	$14,000
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	145	$57,342	5	11.50	$335	$2,663	3	11.63	$385	$1,875	15	11.32	$312	$6,106	10	11.79	$423	$7,563	28	11.06	$252	$7,312
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0

TABLE F.14 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, AGES 22+
WAIVER STRATEGY

			ALL	6 OTHER SSL				7 DEV-DVRDG SSL				8 CHRONIC SSL				9 OTHER SSL				10 OTHER SSL			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	145	$17,980	18	1	$124	$2,232	9	1	$124	$1,116	24	1	$124	$2,976	33	1	$124	$4,092	0	1	$124	$0
INDIV PLNG & MONITORING	Hours	145	$208,075	18	41	$35	$25,830	9	41	$35	$12,915	24	41	$35	$34,440	33	41	$35	$47,355	0	41	$35	$0
CLUSTER MANAGEMENT	Client	145	$217,500	18	1	$1,500	$27,000	9	1	$1,500	$13,500	24	1	$1,500	$36,000	33	1	$1,500	$49,500	0	1	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	3	$360,630	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR IVB BEHVR MGMT	Days	3	$243,090	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	365	$127	$0	0	365	$186	$0	0	365	$86	$0	0	365	$53	$0	0	365	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME IVB BEHVR MGMT	Days	19	$1,107,410	0	365	$95	$0	9	365	$146	$479,610	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME III HIGH SUPV	Days	45	$830,400	0	365	$95	$0	0	365	$146	$0	0	365	$57	$0	33	365	$28	$337,260	0	365	$24	$0
GRP HOME II MOD SUPV	Days	33	$1,320,009	13	365	$95	$456,905	0	365	$146	$0	0	365	$57	$0	0	365	$28	$0	0	365	$24	$0
GRP HOME I MIN SUPV	Days	31	$468,222	0	365	$95	$0	0	365	$146	$0	14	365	$57	$299,592	17	365	$28	$168,630	0	365	$24	$0
SPEC CARE IV FAMILY	Days	3	$32,850	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
MED CARE III FAMILY	Days	1	$12,264	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE IIIFAMILY	Days	10	$98,331	3	365	$25	$49,275	0	365	$30	$0	0	365	$25	$0	0	365	$20	$0	0	365	$15	$0
SPEC CARE II FAMILY	Days	20	$139,870	0	365	$25	$0	0	365	$30	$0	10	365	$25	$67,600	10	365	$20	$72,270	0	365	$15	$0
SPEC CARE I FAMILY	Days	7	$40,100	0	365	$25	$0	0	365	$30	$0	0	365	$25	$0	7	365	$20	$40,100	0	365	$15	$0
INDEPENDENT W/RELATIVES	Days	0	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0	0	365	$10	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
SEGREGATED INF ST/PRE-SCI	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
INTEGRATED INF ST/PRE-SCI	Days	0	$0	0	240	$31	$0	0	240	$30	$0	0	240	$23	$0	0	240	$20	$0	0	240	$19	$0
WORK ACTIVITY	Days	60	$376,600	4	240	$32	$27,648	0	240	$40	$0	0	240	$29	$0	0	240	$25	$0	0	240	$22	$0
SHELTERED WORK	Days	46	$365,616	9	240	$32	$69,120	7	240	$40	$69,120	10	240	$29	$66,016	7	240	$25	$39,600	0	240	$22	$0
INTEGRATED ADULT SVCS	Days	35	$234,468	3	240	$32	$41,472	2	240	$40	$17,200	10	240	$29	$66,016	18	240	$25	$100,900	0	240	$22	$0
SUPPORTED EMPLOYMENT	Days	13	$62,181	0	240	$24	$0	0	240	$30	$0	3	240	$22	$25,056	8	240	$19	$37,125	0	240	$17	$0
HOME-BASED TRAINING	Hours	0	$0	0	600	$16	$0	0	700	$16	$0	0	600	$16	$0	0	500	$16	$0	0	500	$16	$0
SPCH & HRNG THERAPY	Hours	46	$161,710	6	96	$33	$19,160	4	140	$33	$16,001	6	120	$33	$23,283	11	130	$33	$46,377	0	130	$33	$0
PHYSICAL THERAPY	Hours	43	$67,073	6	48	$33	$9,979	2	48	$33	$3,049	11	48	$33	$17,107	6	48	$33	$8,907	0	48	$33	$0
OCCUPATIONAL THERAPY	Hours	68	$46,182	9	21	$25	$4,899	3	60	$25	$4,374	16	28	$25	$11,249	8	26	$25	$5,097	0	31	$25	$0
CRISES INTERVENTION	Client	14	$2,192	1	1	$136	$404	3	1	$136	$463	3	1	$136	$407	1	1	$136	$103	0	1	$136	$0
BEHAVIORAL CONSULTATION	Hours	43	$209,137	3	160	$35	$23,137	9	239	$35	$73,411	4	120	$35	$18,702	3	160	$35	$27,651	0	200	$35	$0
. PSYCHO- THERAPY	Hours	4	$1,733	0	40	$8	$115	1	72	$8	$310	0	36	$8	$130	0	48	$8	$127	0	60	$8	$0
PERSONAL CARE SVCS	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	30	$57	$0	0	30	$57	$0
TRANSPORT- ATION	Client	0	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0	0	1	$1,000	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
PREVENTION/ MAINTENANCE	Client	137	$23,900	18	1	$150	$2,700	9	1	$200	$1,800	24	1	$125	$3,000	33	1	$100	$3,300	0	1	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	75	$57	$0	0	150	$57	$0	0	75	$57	$0	0	30	$57	$0	0	30	$57	$0
ACUTE CARE	Client	145	$72,500	18	1	$500	$9,000	9	1	$500	$4,500	24	1	$500	$12,000	33	1	$500	$16,500	0	1	$500	$0
		0	$0	0			$0	0			$0	0			$0	0			$0	0			$0
STAFF TRAINING	Staff	145	$57,342	18	0.99	$235	$4,197	9	1.53	$362	$4,972	24	0.85	$200	$4,072	33	1.56	$364	$18,301	0	0.00	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0	0	1	$5,000	$0
LEVEL IV RESPITE	Days	0	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0	0	30	$50	$0
LEVEL III RESPITE	Days	0	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0	0	28	$40	$0
LEVEL II RESPITE	Days	0	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0	0	21	$30	$0
LEVEL I RESPITE	Days	0	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0	0	21	$25	$0

TABLE F.15
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, ALL AGES
WAIVER STRATEGY

YEAR 0

TYPE OF SERVICE	UNIT TYPE	ALL(1-10) INDIV #	ALL(1-10) TOTAL COST	1 MED/PHYS OVRDG SKL1 INDIV #	UNIT #	UNIT COST	TOTAL COST	2 BEH-OVRDG SKL1 INDIV #	UNIT #	UNIT COST	TOTAL COST	3 CHRONIC&OTHER SKL1 INDIV #	UNIT #	UNIT COST	TOTAL COST	4 BEH-OVRDG SKL2 INDIV #	UNIT #	UNIT COST	TOTAL COST	5 CHRONIC SKL2 INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	221	$27,404	15	1	$124	$1,860	10	1	$124	$1,240	19	1	$124	$2,356	17	1	$124	$2,108	42	1	$124	$5,208
INDIV PLNG & MONITORING	Hours	221	$317,133	15	41	$35	$21,525	10	41	$35	$14,350	19	41	$35	$27,265	17	41	$35	$24,395	42	41	$35	$60,270
CLUSTER MANAGEMENT	Client	221	$331,500	15	1	$1,500	$22,500	10	1	$1,500	$15,000	19	1	$1,500	$28,500	17	1	$1,500	$25,500	42	1	$1,500	$63,000
ICF-MR IVA MEDCL SUPV	Days	15	$1,105,950	15	365	$202	$1,105,950	0	0	$222	$0	0	0	$159	$0	0	0	$219	$0	0	0	$143	$0
ICF-MR IVB BEHVR MGMT	Days	10	$810,300	0	0	$202	$0	10	365	$222	$810,300	0	0	$159	$0	0	0	$219	$0	0	0	$143	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$202	$0	0	0	$222	$0	0	0	$159	$0	0	0	$219	$0	0	0	$143	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
GRP HOME IVB BEHVR MGMT	Days	32	$1,066,610	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	17	365	$172	$1,067,260	0	0	$109	$0
GRP HOME III HIGH SUPV	Days	61	$1,121,645	0	0	$139	$0	0	0	$172	$0	15	365	$119	$651,525	0	0	$172	$0	0	0	$109	$0
GRP HOME II MOD SUPV	Days	62	$2,096,743	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	34	365	$109	$1,336,776
GRP HOME I MIN SUPV	Days	31	$460,222	0	0	$139	$0	0	0	$172	$0	0	0	$119	$0	0	0	$172	$0	0	0	$109	$0
SPEC CARE IV FAMILY	Days	3	$37,230	0	0	$34	$0	0	0	$34	$0	3	365	$34	$37,230	0	0	$34	$0	0	0	$34	$0
MED CARE III FAMILY	Days	1	$15,330	0	0	$42	$0	0	0	$42	$0	0	0	$42	$0	0	0	$42	$0	1	365	$42	$15,330
SPEC CARE IIIFAMILY	Days	12	$123,370	0	0	$28	$0	0	0	$28	$0	0	0	$28	$0	0	0	$28	$0	6	365	$28	$61,320
SPEC CARE II FAMILY	Days	25	$200,750	0	0	$22	$0	0	0	$22	$0	0	0	$22	$0	0	0	$22	$0	0	0	$22	$0
SPEC CARE I FAMILY	Days	9	$67,160	0	0	$23	$0	0	0	$23	$0	0	0	$23	$0	0	0	$23	$0	0	0	$23	$0
INDEPENDENT W/RELATIVES	Days	5	$19,973	0	0	$10	$0	0	0	$10	$0	1	365	$10	$2,219	0	0	$10	$0	1	365	$10	$5,170
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	3	$19,336	0	0	$38	$0	0	0	$36	$0	1	240	$31	$10,416	0	0	$33	$0	0	0	$33	$0
INTEGRATED INF ST/PRE-SC	Days	3	$19,152	0	0	$38	$0	0	0	$36	$0	0	240	$31	$1,488	0	0	$35	$0	0	0	$33	$0
WORK ACTIVITY	Days	40	$376,600	0	0	$43	$0	0	0	$50	$0	12	240	$40	$115,200	10	240	$47	$112,800	14	240	$36	$120,960
SHELTERED WORK	Days	46	$363,616	0	0	$43	$0	0	0	$50	$0	0	0	$40	$0	0	0	$47	$0	14	240	$36	$120,960
INTEGRATED ADULT SVCS	Days	35	$234,460	0	0	$43	$0	0	0	$50	$0	0	0	$40	$0	0	0	$47	$0	0	0	$36	$0
SUPPORTED EMPLOYMENT	Days	16	$73,213	0	0	$32	$0	0	0	$30	$0	0	0	$30	$0	0	0	$33	$0	0	0	$27	$0
HOME-BASED TRAINING	Hours	12	$105,760	0	0	$16	$0	0	0	$16	$0	1	600	$16	$9,600	0	0	$16	$0	3	600	$16	$28,800
SPCH & HRNG THERAPY	Hours	40	$170,126	0	0	$30	$0	0	0	$33	$0	7	60	$33	$12,939	4	110	$33	$12,705	10	96	$33	$31,667
PHYSICAL THERAPY	Hours	45	$71,961	0	0	$30	$0	0	0	$33	$0	5	48	$33	$8,617	1	48	$33	$1,799	12	48	$33	$18,620
OCCUPATIONAL THERAPY	Hours	60	$46,182	0	0	$30	$0	0	0	$25	$0	8	24	$25	$4,666	6	32	$25	$5,011	18	24	$25	$10,806
CRISES INTERVENTION	Client	21	$3,330	0	0	$136	$0	2	1	$136	$230	1	1	$136	$212	3	1	$136	$330	5	1	$136	$721
BEHAVIORAL CONSULTATION	Hours	60	$450,310	0	0	$35	$0	0	0	$35	$0	4	160	$35	$21,227	17	239	$35	$142,443	13	133	$35	$62,363
PSYCHO- THERAPY	Hours	6	$2,725	0	0	$60	$0	0	0	$60	$0	1	24	$60	$146	2	72	$60	$979	1	32	$60	$215
PERSONAL CARE SVCS	Visit	5	$27,210	0	0	$37	$0	0	0	$37	$0	1	200	$37	$6,840	0	0	$37	$0	1	100	$57	$7,980
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	196	$34,350	0	0	$600	$0	0	0	$400	$0	19	1	$300	$5,700	17	1	$300	$5,100	42	1	$200	$8,400
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	221	$290,500	15	1	$2,750	$40,500	10	1	$2,750	$13,500	19	1	$2,750	$27,300	17	1	$2,750	$19,000	42	1	$2,750	$42,000
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	221	$86,191	15	2	$355	$7,989	10	2	$385	$6,250	19	1	$276	$7,033	17	2	$403	$11,938	42	1	$236	$10,317
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0	0	0	$5,000	$0
LEVEL IV RESPITE	Days	1	$900	0	0	$30	$0	0	0	$30	$0	1	30	$30	$900	0	0	$30	$0	0	0	$30	$0
LEVEL III RESPITE	Days	2	$2,072	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	1	20	$40	$1,360
LEVEL II RESPITE	Days	2	$1,386	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0	0	0	$30	$0
LEVEL I RESPITE	Days	1	$394	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0

TABLE F.15 p2
PROJECTED SERVICE REQUIREMENTS AND COSTS
SW GEORGIA AREA WAITING LISTS, ALL AGES
WAIVER STRATEGY

		ALL		6 OTHER SKL2				7 BEH-DVRBG SKL3				8 CHRONIC SKL3				9 OTHER SKL3				10 OTHER SKL4			
TYPE OF SERVICE	UNIT TYPE	INDIV #	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST	INDIV #	UNIT #	UNIT COST	TOTAL COST
DIAGNOSIS & EVALUATION	Client	221	$27,404	25	1	$124	$3,100	15	1	$124	$1,860	32	1	$124	$3,968	46	1	$124	$5,704	0	0	$124	$0
INDIV PLNG & MONITORING	Hours	221	$317,135	25	41	$35	$35,875	15	41	$35	$21,525	32	41	$35	$45,920	46	41	$35	$66,010	0	0	$35	$0
CLUSTER MANAGEMENT	Client	221	$331,500	25	1	$1,500	$37,500	15	1	$1,500	$22,500	32	1	$1,500	$48,000	46	1	$1,500	$69,000	0	0	$1,500	$0
ICF-MR IVA MEDCL SUPV	Days	15	$1,103,950	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
ICF-MR IVB BEHVR MGMT	Days	10	$810,300	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
ICF-MR III HIGH SUPV	Days	0	$0	0	0	$127	$0	0	0	$186	$0	0	0	$86	$0	0	0	$53	$0	0	0	$46	$0
GRP HOME IVA MEDCL SUPV	Days	0	$0	0	0	$95	$0	0	0	$146	$0	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME IVB BEHVR MGMT	Days	32	$1,066,610	0	0	$95	$0	15	365	$146	$799,350	0	0	$57	$0	0	0	$28	$0	0	0	$24	$0
GRP HOME III HIGH SUPV	Days	61	$1,121,445	0	0	$95	$0	0	0	$146	$0	0	0	$57	$0	46	365	$28	$470,120	0	0	$24	$0
GRP HOME II MOD SUPV	Days	62	$2,096,743	17	365	$95	$599,070	0	0	$146	$0	5	365	$57	$95,703	6	365	$28	$64,386	0	0	$24	$0
GRP HOME I MIN SUPV	Days	31	$468,222	0	0	$95	$0	0	0	$146	$0	14	365	$57	$299,592	17	365	$28	$160,630	0	0	$24	$0
SPEC CARE IV FAMILY	Days	3	$37,230	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
MED CARE III FAMILY	Days	1	$15,330	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
SPEC CARE IIIFAMILY	Days	12	$123,370	7	365	$25	$62,050	0	0	$30	$0	0	0	$25	$0	0	0	$20	$0	0	0	$15	$0
SPEC CARE II FAMILY	Days	25	$200,750	0	0	$25	$0	0	0	$30	$0	12	365	$25	$109,500	13	365	$20	$91,250	0	0	$15	$0
SPEC CARE I FAMILY	Days	9	$67,160	0	0	$25	$0	0	0	$30	$0	0	0	$25	$0	9	365	$20	$67,160	0	0	$15	$0
INDEPENDENT W/RELATIVES	Days	5	$19,973	1	365	$10	$3,329	0	0	$10	$0	1	365	$10	$3,699	2	365	$10	$5,340	0	0	$10	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
SEGREGATED INF ST/PRE-SC	Days	3	$19,336	1	240	$31	$5,952	0	0	$30	$0	0	240	$23	$2,200	0	240	$20	$960	0	0	$19	$0
INTEGRATED INF ST/PRE-SC	Days	3	$19,132	1	240	$31	$4,464	0	0	$30	$0	1	240	$23	$5,520	2	240	$20	$7,600	0	0	$19	$0
WORK ACTIVITY	Days	60	$376,600	4	240	$32	$27,648	0	0	$40	$0	0	0	$29	$0	0	0	$25	$0	0	0	$22	$0
SHELTERED WORK	Days	46	$365,616	9	240	$32	$69,120	7	240	$40	$69,120	10	240	$29	$66,016	7	240	$25	$39,600	0	0	$22	$0
INTEGRATED ADULT SVCS	Days	33	$234,460	5	240	$32	$41,472	2	240	$40	$17,280	10	240	$29	$66,016	18	240	$25	$100,900	0	0	$22	$0
SUPPORTED EMPLOYMENT	Days	16	$75,213	0	0	$24	$0	0	0	$30	$0	3	240	$22	$20,100	10	240	$19	$47,025	0	0	$17	$0
HOME-BASED TRAINING	Hours	12	$105,760	2	600	$16	$20,160	0	0	$16	$0	2	600	$16	$23,040	4	500	$16	$20,000	0	0	$16	$0
SPCH & HRNG THERAPY	Hours	48	$170,126	7	96	$33	$21,289	4	140	$33	$16,001	6	120	$33	$25,225	12	130	$33	$49,399	0	0	$33	$0
PHYSICAL THERAPY	Hours	43	$71,961	7	40	$33	$11,088	2	40	$33	$3,049	12	40	$33	$10,333	6	40	$33	$9,447	0	0	$33	$0
OCCUPATIONAL THERAPY	Hours	60	$46,182	9	21	$25	$4,099	3	60	$25	$4,374	16	28	$25	$11,249	8	.26	$25	$5,097	0	0	$25	$0
CRISES INTERVENTION	Client	21	$3,330	1	1	$136	$100	5	1	$136	$772	4	1	$136	$600	1	1	$136	$137	0	0	$136	$0
BEHAVIORAL CONSULTATION	Hours	60	$450,310	6	160	$35	$34,913	15	239	$35	$125,605	6	120	$35	$24,936	7	160	$35	$38,343	0	0	$35	$0
PSYCHO- THERAPY	Hours	6	$2,725	1	40	$4	$160	2	72	$4	$864	1	36	$4	$184	0	40	$4	$177	0	0	$4	$0
PERSONAL CARE SVCS	Visit	5	$27,210	1	75	$57	$3,840	0	0	$57	$0	1	75	$57	$4,275	2	30	$57	$4,275	0	0	$57	$0
TRANSPORT- ATION	Client	0	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0	0	0	$1,000	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
PREVENTION/ MAINTENANCE	Client	196	$34,330	25	1	$150	$3,750	15	1	$200	$3,000	32	1	$125	$4,000	46	1	$100	$4,600	0	0	$200	$0
HOME HEALTH SERVICES	Visit	0	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0	0	0	$57	$0
ACUTE CARE	Client	221	$290,500	25	1	$2,750	$35,000	15	1	$2,750	$16,300	32	1	$2,750	$40,000	46	1	$2,750	$34,500	0	0	$300	$0
		0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0	0	0	$0	$0
STAFF TRAINING	Staff	221	$86,191	25	1	$213	$5,271	15	1	$304	$7,637	32	1	$103	$5,018	46	2	$308	$24,717	0	0	$0	$0
FAMILY EDUC & SUPPORT	Client	0	$0	0	0	$3,000	$0	0	0	$3,000	$0	0	0	$3,000	$0	0	0	$3,000	$0	0	0	$3,000	$0
LEVEL IV RESPITE	Days	1	$900	0	0	$30	$0	0	0	$50	$0	0	0	$50	$0	0	0	$30	$0	0	0	$30	$0
LEVEL III RESPITE	Days	2	$2,072	0	20	$40	$504	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0	0	0	$40	$0
LEVEL II RESPITE	Days	2	$1,306	0	21	$30	$204	0	0	$30	$0	1	21	$30	$630	1	21	$30	$473	0	0	$30	$0
LEVEL I RESPITE	Days	1	$394	0	0	$25	$0	0	0	$25	$0	0	0	$25	$0	1	21	$25	$394	0	0	$25	$0

APPENDIX G:

PROPOSED MODEL OF IOWA STATE-WIDE DIRECT CARE STAFF TRAINING PROGRAM

(Pprepared by Human Services Research Institute)

PROPOSED MODEL FOR A STATEWIDE DIRECT CARE STAFF TRAINING SYSTEM

(July, 1987)

PURPOSES OF A TRAINING SYSTEM:

1. To assure that direct care staff are prepared to provide exemplary services;
2. To elevate the professional status and self-esteem of direct care staff; and
3. To provide present and future direct care staff with the philosophic understanding and service related skills needed to provide exemplary services to consumers.

DESCRIPTION OF TRAINING MODEL:

A three part training system to meet the above purposes is proposed:

1) Pre-service education;
2) Orientation; and
3) In-service training.

The Pre-service component pertains to state mandated training required of all direct care staff working in adult day or residential community-based settings. The second two components comprise a voluntary staff training program. Agencies would be provided sufficient monies to meet the mandated staff training requirement. Agencies who participate in the voluntary training program would be provided additional funding to meet the requirements of the training program. Providers who successfully implement the system would recieve further funds as an "incentive" to continued participation.

Each of the three components of the training system is described below according to its: 1) purpose, 2) requirements, 3) content, and 4) delivery mechanism. This is followed by a description of the administrative and fiscal mechanisms proposed to support the whole training system.

I. PRE-SERVICE EDUCATION (Mandated)

Purposes: The purposes of this component are: 1) to assure that staff possess fundamental knowledge regarding persons with disabilities, and 2) to build a knowledgeable labor pool from which staff may be selected.

Requirements: All prospective regular full-time and part-time direct care staff must have successfully demonstrated competence in pre-service education topics prior to any contact with consumers. Competence would be assessed via a written test (unless other testing procedures are approved) and a pre-service education certificate would be available to demonstrate successful completion of this requirement.

At the time of implementation of this requirement, all currently employed direct care staff would have up to two years in which they may obtain pre-service education certification. All current and future employees also have the option of "testing out" of the requirement without undergoing new training. All persons who have successfully completed the state-sponsored resident attendant course would be exempted from this requirement. Any person who has previously secured pre-service certification may have consumer contact immediately upon employment.

Instructional Content: The proposed content of pre-service education is shown in Figure 1. Content is designed to provide information relevant to serving consumers with varying disabilities in diverse settings. It is anticipated that pre-service students can meet these training objectives given 15-20 hours of instruction.

Delivery Mechanism: It is anticipated that course work in these topics, testing, and certification would be available through the community college network for a tuition fee. Due to the diverse needs of providers, however, instruction also can be made available to prospective staff, at no charge to staff, through self-taught modules and/or through senior agency staff. In these cases, agency training proctors would be approved, and would be responsible for instruction, testing and certification.

II. AGENCY ORIENTATION (Voluntary)

Purposes: The purposes of this component are: 1) to provide direct care staff with sufficient, though introductory, information for offering to consumers an appropriate habilitative environment without ongoing supervision, and 2) to assure that staff are aware of agency policies and procedures, and relevant state and local systems requirements.

Requirements: All agencies who elect to participate in the voluntary training system must provide orientation to all newly hired full time direct care staff. Orientation must take place within the first 20 hours of employment and must be completed by new staff prior to unsupervised direct client contact. Agencies participating in the program must provide an annual plan of how orientation is delivered, the topics covered, and documentation of the orientation of newly hired employees.

Instructional Content: The agency orientation plan must include orientation in at least the core topics listed in Figure 1. It is anticipated that 15-20 hours is necessary to provide orientation on core topics. Participating agencies may also elect to send some or all staff to training in the optional orientation topics listed in Figure 1. Any expectations pertaining to instructing new employees in the optional topics should be listed in the agency's Staff Training Plan (See page 4).

Delivery Mechanism: Instruction in orientation core topics would be delivered by senior agency personnel. Training in advanced topics would be delivered by agency staff who are competent to do so, or by professionals external to the agency (e.g., Red Cross workers). Orientation should be include at least five hours of job shadowing by new employees.

III. INSERVICE TRAINING AND CONTINUING EDUCATION (Voluntary)

Purposes: The purpose of this component is to assure the ongoing development of those staff competencies needed to provide exemplary services.

Requirements: Inservice training pertaining to this component is offered after the Pre-service and Orientation instruction has been completed and it is divided into two sub-sections:

- Basic skills training: Agencies participating in the staff development program must provide their direct care staff with at least 50 hours of instruction in their first year of employment to acquire competencies listed in Figure 1 under the "basic skills" category. Of these 50 hours, at least 10 would be spent "on-the-job" to provide staff opportunity to test new competencies while under the supervision of persons qualified to offer constructive feedback; and

- Advanced skills training and/or exceptional habilitation: After staff have mastered basic skills competencies, they shall be provided with 25-32 hours/year of continuing education to acquire advanced habilitative skills and/or information on relevant specialty topics (See Figure 1). Staff ought not receive this level of instruction before they have mastered basic skills, though exceptions to this rule of thumb may arise.

Staff who have successfully completed Basic Skill and/or Advanced Skills training would be certified. This certificate would exempt that employee from undergoing comparable training at another agency.

Instructional Content: Staff ought to receive instruction regarding Basic Skills Training topics (See Figure 1) during their first year of employment. Training in topics listed under the Advanced Skills section would be offered in the second and subsequent years of employment. Training in specialty topics is left to the discretion of the provider given the context of specific agency consumers and services. Materials for acheiving competency in these topics may be recommended, but no single curriculum is recognized.

Delivery Mechanism: No single delivery method of inservice training is required, although certain instructors, workshops or materials may be recommended as they prove to be the most effective. Because training funds are limited, agencies would be encouraged to organize, and make efficient use of training delivery resources.

IV. ADMINISTRATIVE AND FISCAL MECHANISMS TO SUPPORT TRAINING EFFORT

Three administrative mechanisms are proposed to assure successful implementation of a "state-of-the-art" staff training system.

1. Standing training committee to assure ongoing communications: In any service system divergent interests exist, spurring periodic conflict among various players (e.g., state officials, advocates, service providers). Though excessive conflict is undesirable, systems dominated by a single interest (e.g., a "provider" or "state" driven system) may well grow resistant to needed change that reflects progressive habilitative concepts. Moreover, players whose opinions are not taken into account may grow increasingly discontent over time, generating a new round of conflict.

Regarding staff development, a standing committee composed of representatives of the above groups would be established to assure ongoing communication and cooperation among key players. This committee would devise means to: 1) review the staff development program implemented, making adjustments to the program's content and administrative process as warranted; 2) approve "Staff Training Plans" prepared by each participating provider agency; 3) make recommendations regarding curricula or instructors to be used;

4) up-date required training topics to reflect current developments in the field; 5) advise on or prepare equitable funding formulae for distribution of training dollars to individual facilities; and, 6) devise alternate means of evaluating agency plans or training effectiveness.

2. State Training Administrator: A new state position should be created to administer the proposed system. The range of duties may include: 1) organize and facilitate the standing training committee described above; 2) organize the development or acquisition of training materials such as self-taught modules; pre-service exams, 3) provide guidelines to agencies on how to prepare staff training plans; 4) assist proctors in securing and returning pre-service exams and certificates; 5) maintain a list of persons who have achieved inservice certification; and 6) advocate for training resources.

3. Staff Training Plan: Providers electing to participate in the staff development program must prepare a plan that describes what training would be provided, and how staff would receive the training planned. The plan must account for activities that would meet the timeframes and content specifications of the Orientation and Inservice training components (i.e., basic skills, advanced skills, specialty topics) as shown in Figure 1. Additionally, the plan must specify how money received as an incentive for implementing the plan (see below) would be spent. This plan must be approved by some external party, e.g., the standing committee on staff development. Implementation of each provider plan should be documented and would be evaluated systematically.

Financing of the proposed staff development system involves three considerations:

1) Operating budget: Whether or not providers elect to participate in the voluntary training program, each would receive 100% of their typical operating budget. No portion of this budget would be forfeited by providers if they elect not to participate. Budgets would be amplified if necessary to account for pre-service education (mandated) costs of new or on-going staff.

2) Staff training budget: Based on their operating budget and other considerations (e.g., proximity to training resources, turnover rates), providers participating in the voluntary staff development system would receive funding that MUST be spent to cover the costs of training. Thus, the staff development plan must be prepared with an eye on the amount of money that would be available for its implementation. An equitable formula would be devised to determine the number of dollars available for training. Monies would be sufficient to cover the relief time necessary to release staff and for ancillary expenses associated with training for orientation and in-service training. With time, funding formulae may be adjusted to assure that sufficient resources are available to cover training costs.

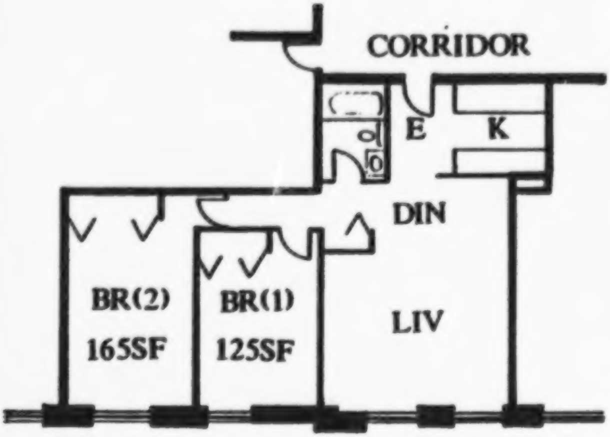
3) Training incentive: Pending successful implementation of the staff development plan, participating providers would receive some percentage of their personnel budget as a "reward." Incentive dollars MUST be spent in ways to accommodate personnel needs (e.g., salary increases). These dollars cannot be used to substitute for dollars typically set aside for staff (e.g., merit or cost of living pay increases), or to offset training costs or other operating expenses. In essence, the incentive dollars must be used on behalf of direct care personnel, as specified in the staff development plan.

APPENDIX H

Residential Facilities: Architectural Designs and Estimated Costs

1.2.1

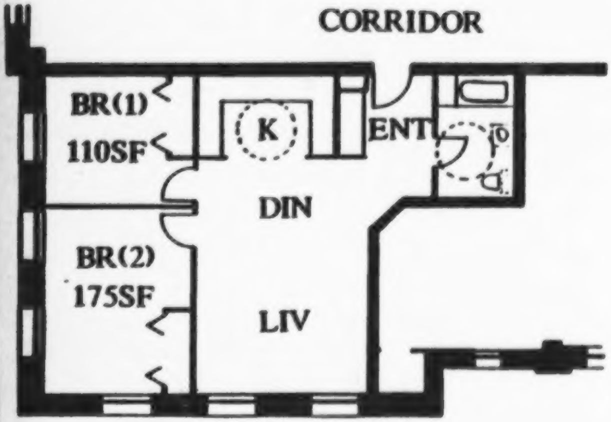
APARTMENT RENOVATION AMBULATORY


CORRIDOR
E
K
DIN
BR(2)
165SF
BR(1)
125SF
LIV

A typical 2-bedroom apartment in a multilevel building provides an independent living option for 2 or 3 ambulatory resident, depending on bedroom size.

1.2.2

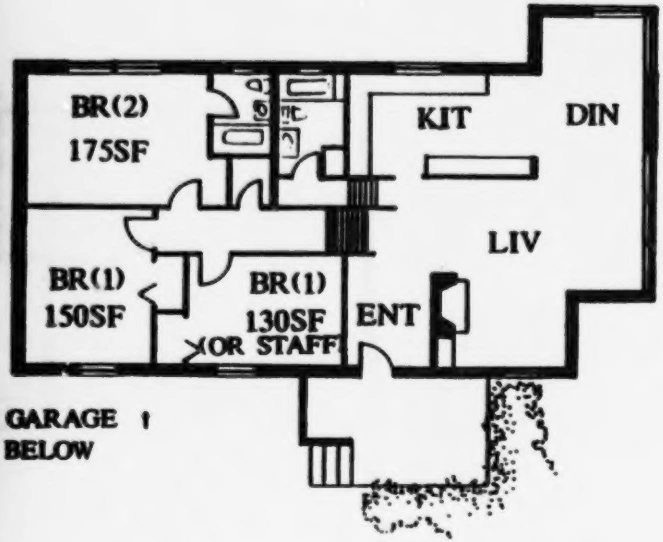
APARTMENT RENOVATION NONAMBULATORY


CORRIDOR
BR(1)
110SF
K
ENT
DIN
BR(2)
175SF
LIV

Characteristic of apartments designed to accommodate handicapped persons, a dwelling unit of this type can provide an independent living environment for 2 or 3 nonambulatory residents, depending on the size of the bedroom

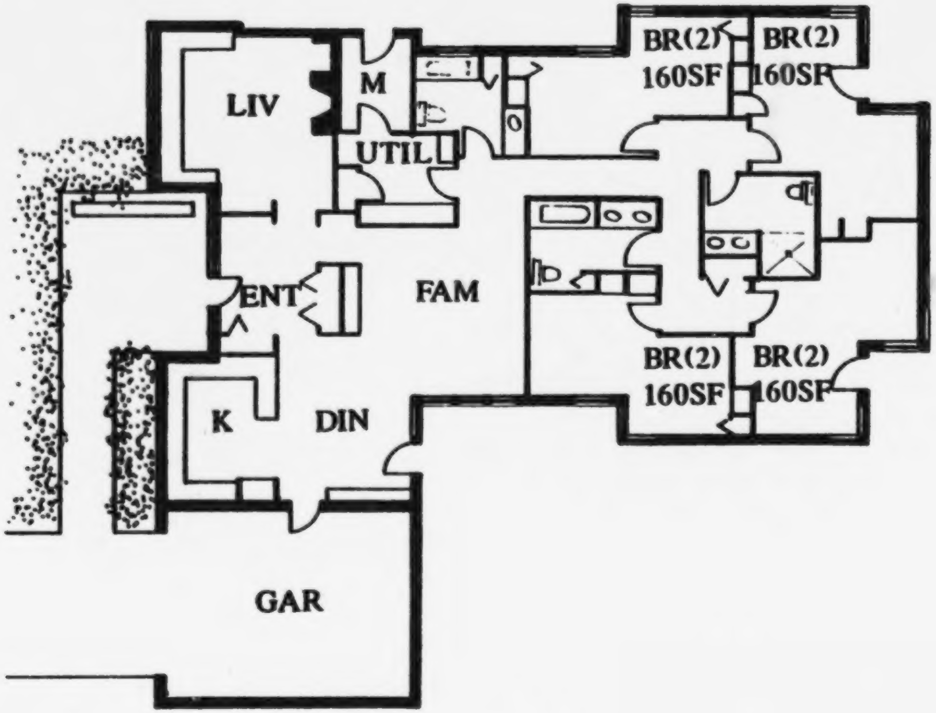
2.2.1

SMALL GROUP HOME
RENOVATION
NONAMBULATORY


BR(2)
175SF
KIT
DIN
LIV
BR(1)
150SF
BR(1)
130SF
OR STAFF
ENT
GARAGE
BELOW

This prototype examines the use of a typical 3-bedroom split-level house, with only minor renovations, to serve as a small group home for 3 or 4 residents. The split-level character limits the use of this house to ambulatory residents. One bedroom can be dedicated for staff if sleep-in staffing is used.

3.1.1 FACILITY FOR AMBULATORY RESIDENTS IS SIMILAR, WITHOUT SPECIAL BATH AND KITCHEN PROVISIONS.

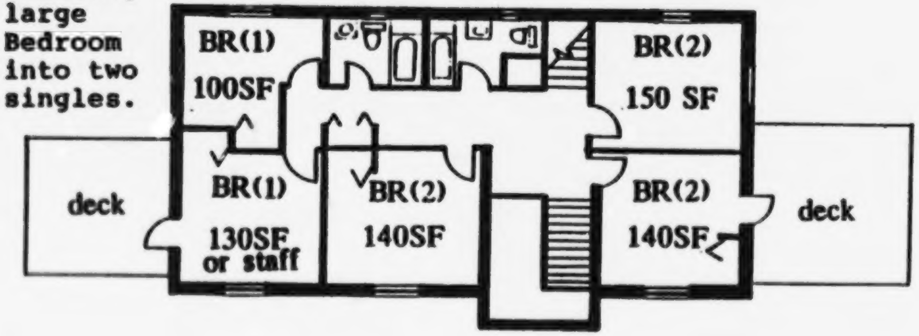

BR(2)
160SF
BR(2)
160SF
LIV
M
UTIL
ENT
FAM
BR(2)
160SF
BR(2)
160SF
K
DIN
GAR

3.1.2

LARGE GROUP HOME
NEW CONSTRUCTION
NONAMBULATORY

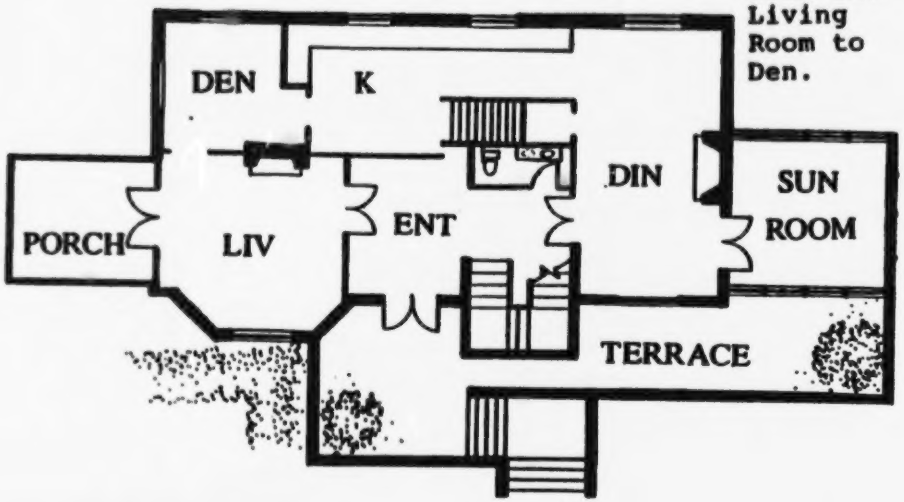
This prototype demonstrates a new group home designed to fit into a typical suburban neighborhood. The normal living environment includes staff facilities integrated into typical residential spaces and furnishings.

Possible subdivision of existing large Bedroom into two singles.


BR(1)
100SF
BR(2)
150 SF
deck
BR(1)
130SF or staff
BR(2)
140SF
BR(2)
140SF
deck

SECOND FLOOR

Remodel Kitchen; open Kitchen to Dining Room and Living Room to Den.


DEN
K
DIN
SUN ROOM
PORCH
LIV
ENT
TERRACE

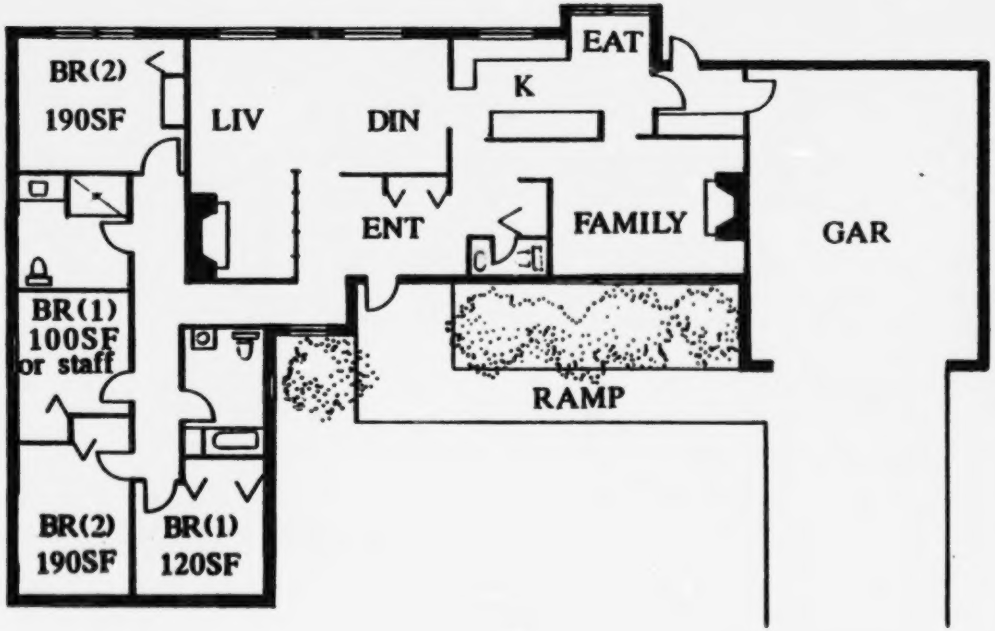
FIRST FLOOR

3.2.1

LARGE GROUP HOME RENOVATED AMBULATORY

Typical of many older houses, this prototype demonstrates the possible renovation of a 2-story, 4-bedroom house to create a group home for 6 to 8 ambulatory residents, depending on the extent of renovation and the need for sleep-in staffing.

2.2.2 SMALL GROUP HOME FOR NONAMBULATORY RESIDENTS IS SIMILAR; EXISTING HOUSE WOULD BE 3-BEDROOM MODEL.


BR(2)
190SF
LIV
DIN
EAT
K
ENT
FAMILY
GAR
BR(1)
100SF
or staff
RAMP
BR(2)
190SF
BR(1)
120SF

Renovate Kitchen and Bathrooms for handicapped access.

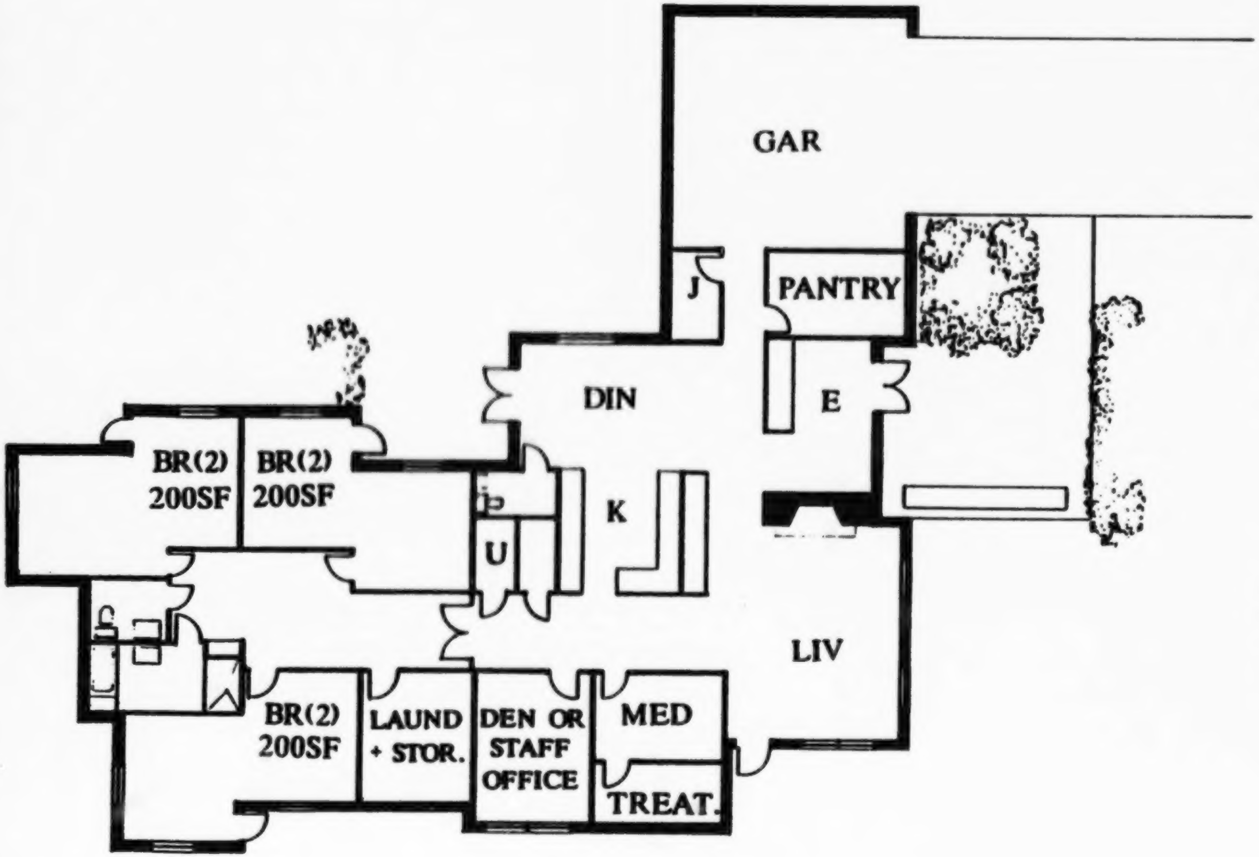
3.2.2

LARGE GROUP HOME RENOVATION NONAMBULATORY

This prototype adapts a standard four-bedroom ranch house to meet the needs of 4 to 6 nonambulatory residents, depending on bedroom size and the need for sleep-in staffing.

4.1.1

SMALL ICF-MR


GAR
J
PANTRY
DIN
E
BR(2) 200SF
BR(2) 200SF
K
U
LIV
BR(2) 200SF
LAUND + STOR.
DEN OR STAFF OFFICE
MED
TREAT.

4.1.2

NEW CONSTRUCTION

AMBULATORY AND NONAMBULATORY

This prototype provides for the special requirements of an Intermediate Care Home in a setting that emphasizes a normal home environment for the six residents.

6022-PSX.WK3 9.28.87
Environmental Design Group 6022

GEORGIA FEASIBILITY STUDY: RESIDENTIAL OPTIONS
MR Facilities

Residential Option: 1. APARTMENTS (2-3 beds)	Applicable Codes & Regs.	Key Const. Cost Impacts	Construction Costs: Per Site	Acquisition Costs (lot or bldg.purchase) Per Site		Development Costs (@ 10% of const. & acquisition)		F&E Costs	TOTAL COST			
				High	Low	High	Low		High Per Site	High Per Bed	Low Per Site	Low Per Bed
1.1 New Construction	N/A											
1.1.1 Ambulatory												
1.1.2 Nonambulatory												
1.2 Renovation												
1.2.1 Ambulatory	(1)Local Zoning (2)Local Bldg.Code		$0	$65,000 2BR Condo. Dekalb Co. or $700/mo 2BR Apt. Dekalb Co.	$48,000 2BR Condo. Lowndes Co. (avg) or $250/mo 2BR Apt. Lowndes Co. (avg)	$6,500	$4,800	$15,000	$87,300 (All bedrooms are used for residents: total = 3 beds)	$29,100	$68,600	$22,867
1.2.2 Nonambulatory	(1)Local Zoning (2)Local Bldg.Code (3)ANSI Stds.for HP	(3) HP Bathroom.Kitch.	$4,500 Available 2BR units will probably provide space for 3 beds.	$65,000 2BR Condo. Dekalb Co. or $700/mo 2BR Apt. Dekalb Co.	$48,000 2BR Condo. Lowndes Co. (avg) or $250/mo 2BR Apt. Lowndes Co. (avg)	$6,950	$5,250	$15,000	$92,250 (All bedrooms are used for residents: total = 3 beds)	$30,750	$73,550	$24,517

6022-PSR.WK3 9.28.87
Environmental Design Group 6022

GEORGIA FEASIBILITY STUDY
MR Facilities

Residential Option: 2. SMALL GROUP HOMES (3-5 beds)	Applicable Codes & Regs.	Key Const. Cost Impacts	Construction Costs: Per Site	Acquisition Costs (lot or bldg.purchase) Per Site: High	Acquisition Costs: Low	Development Costs (@ 10% of const. & acquisition): High	Development Costs: Low	P&E Costs	TOTAL COST High: Per Site	TOTAL COST High: Per Bed	TOTAL COST Low: Per Site	TOTAL COST Low: Per Bed
2.1 New Construction	N/A											
2.1.1 Ambulatory												
2.1.2 Nonambulatory												
2.2 Renovation												
2.2.1 Ambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Min.Req.for Group Homes,GDHR 1974 (4)Personal Care Homes,GDHR 1981 (5)Safety Fire Comr. Proposed Rules	(3) 500CF/bed in BR 1WC/L/T per 6 p Sep.Bathrooms for M/F Multi-level by spec.appvl. Direct exit fr. upper fl.BRs (4)	$11.500	$120,000 3BR SFH. Dekalb Co.	$62.000 3BR SFH. Lowndes Co. (avg)	$13.150	$7.350	$24.400	$169.050 (Case I: all bedrooms used for residents: assume 4 beds) (Case II: one bedroom dedicated to staff: assume 3 beds for residents)	$42.263 $56.350	$105.250	$26.313 $35.083
2.2.2 Nonambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Min.Req.for Group Homes,GDHR 1974 (4)Personal Care Homes,GDHR 1981 (5)Safety Fire Comr. Proposed Rules (6)ANSI Stds.for HP	1WC/L/T per 4p 1WC/L on BR fls. Ramps if HP res. Ramp exit for HP BRs BR=80SF/res., 70SF/res.in renovation 5'clr.betw.beds (5) Emergency ltg. Kit.exhaust hood Smoke detectors Sprinkler system Rated doors @ res.rooms (6)* HP Bathroom,Kitch. Ext.ramps *N/A for nonamb.	$16.500	$120,000 3BR SFH. Dekalb Co.	$62.000 3BR SFH. Lowndes Co. (avg)	$13.650	$7.850	$24.400	$174,550 (Case I: all bedrooms used for residents: assume 4 beds) (Case II: one bedroom dedicated to staff: assume 3 beds for residents)	$43.638 $58.183	$110.750	$27.688 $36.917

Available 3BR houses will probably provide space for 4 beds.

GEORGIA FEASIBILITY STUDY
MR Facilities

Residential Option: 3. LARGE GROUP HOMES (6 - 8 beds)	Applicable Codes & Regs.	Key Const. Cost Impacts	Construction Costs: Per Site	Acquisition Costs (lot or bldg.purchase) Per Site High	Acquisition Costs Per Site Low	Development Costs (@ 10% of const. & acquisition) High	Development Costs Low	F&E Costs	TOTAL COST High Per Site	TOTAL COST High Per Bed	TOTAL COST Low Per Site	TOTAL COST Low Per Bed
3.1 New Construction												
3.1.1 Ambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Min.Req.:Group Homes,GDHR 1974 (4)Personal Care Homes,GDHR 1981 (5)Safety Fire Comr. Proposed Rules	(3) 500CF/res in BR 1WC/L/T per 6p Sep.Bathrooms for M/F Multi-level by spec.appvl. Direct exit fr. upper fl.BRs (4)	$172,000	$45,000 1/2 acre. Dekalb Co.	$11,250 1/2 acre. Lowndes Co. (avg)	$21,700	$18,325	$32,000	$270,700 (Case I: all bedrooms used for residents: assume 8 beds) (Case II: one bedroom dedicated to staff: assume 7 beds for residents)	$33,838 $38,671	$233,575	$29,197 $33,368
3.1.2 Nonambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Min.Req.:Group Homes,GDHR 1974 (4)Personal Care Homes,GDHR 1981 (5)Safety Fire Comr. Proposed Rules (6)ANSI Stds.for HP	1WC/L/T per 4p 1WC/L on BR fls. Ramps if HP res. Ramp exit for HP BRs BR=80SF/res.. 70SF/res.in renovation 5'clr.betw.beds (5)	$177,000 Houses are designed to provide 8 beds.	$45,000 1/2 acre. Dekalb Co.	$11,250 1/2 acre. Lowndes Co. (avg)	$22,200	$18,825	$32,000	$276,200 (Case I: all bedrooms used for residents: assume 8 beds) (Case II: one bedroom dedicated to staff: assume 7 beds for residents)	$34,525 $39,457	$239,075	$29,884 $34,154
3.2 Renovation		Emergency ltg. Kit.exhaust hood										
3.2.1 Ambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Min.Req.:Group Homes,GDHR 1974 (4)Personal Care Homes,GDHR 1981 (5)Safety Fire Comr. Proposed Rules	Smoke detectors Sprinkler system Rated doors @ res.rooms (6)* HP Bathroom.Kitch. Ent.ramps *N/A for nonamb.	$13,940	$135,000 4BR SFH. Dekalb Co.	$67,000 4BR SFH. Lowndes Co.	$14,894	$8,094	$32,000	$195,834 (Case I: all bedrooms used for residents: assume 6 beds) (Case II: one bedroom dedicated to staff: assume 5 beds for residents)	$32,639 $39,167	$121,034	$20,172 $24,207
3.2.2 Nonambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Min.Req.:Group Homes,GDHR 1974 (4)Personal Care Homes,GDHR 1981 (5)Safety Fire Comr. Proposed Rules (6)ANSI Stds.for HP		$18,940 Available 3BR houses will probably provide space for 6 beds without additional renovation cost to create extra bedroom space.	$135,000 4BR SFH. Dekalb Co.	$67,000 4BR SFH. Lowndes Co.	$15,394	$8,594	$32,000	$201,334 (Case I: all bedrooms used for residents: assume 6 beds) (Case II: one bedroom dedicated to staff: assume 5 beds for residents)	$33,556 $40,267	$126,534	$21,089 $25,307

6022-FNX.WK3 9.28.87
Environmental Design Group 6022

GEORGIA FEASIBILITY STUDY
MR Facilities

Residential Option: 6. SMALL ICF-MR (6 beds)	Applicable Codes & Regs.	Key Const. Cost Impacts (code)	Construction Costs: Per Site	Acquisition Costs (lot or bldg.purchase) Per Site High	Low	Develop't Costs (@ 10% of const. & acquisition) High	Low	F&E Costs	TOTAL COST High Per Site	Per Bed	Low Per Site	Per Bed
6.1 New Construction												
6.1.1 Ambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Intermediate Care Homes,GDHR (4)Safety Fire Comr. Proposed Rules (5)Fed.Title XIX Regs. (incl.NFPA 101, 1967 and ANSI Stds.for HP)	(3) 80SF/bed, except single BR=100SF 1WC/L for staff 1WC/L/T/S for res (6 beds). HP incl.Shr. Special areas: Medication. Treatment. Floor Pantry. c/s Utility	$241,900	$45,000 1/2 acre. Dekalb Co.	$19,250 1/2 acre (avg.). Lowndes Co.	$28,690	$26,115	$38,000	$353,590 (All bedrooms are used for residents: total = 6 beds)	$58,932	$325,265	$54,211
6.1.2 Nonambulatory	(1)Local Zoning (2)Local Bldg.Code (3)Intermediate Care Homes,GDHR (4)Safety Fire Comr. Proposed Rules (5)Fed.Title XIX Regs. (incl.NFPA 101, 1967 and ANSI Stds.)	Laund.+c/s Stor. Din/Rec=20SF/bed Staff T's Min.2 Jan.Clos. Doors=44" @ BRs.. Halls=8'w HP access Mech.vent in common areas Emergency ltg.	$241,900 Houses are designed to provide 6 beds.	$45,000 1/2 acre. Dekalb Co.	$19,250 1/2 acre (avg.). Lowndes Co.	$28,690	$26,115	$38,000	$353,590 (All bedrooms are used for residents: total = 6 beds)	$58,932	$325,265	$54,211
6.2 Renovation	N/A	(4) Smoke detectors Sprinkler system Rated doors @ res.rooms (5) HP Bathroom.Kitch. Ent.ramps										
6.2.1 Ambulatory												
6.2.2 Nonambulatory												

APPENDIX I: STEERING COMMITTEE MEMBERS

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